MANULIFE FINANCIAL

**Send Claims to: P. O. Box 4607, Stn. A, Toronto, ON, M5W 4Z3**

STATEMENT OF COVERED EXPENSES FOR HEALTH CARE BENEFITS

PLEASE TYPE OR PRINT. YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS HAVE BEEN ANSWERED IN FULL. USE MORE THAN ONE FORM IF NECESSARY

Employer **DIOCESE OF HURON** Employer Location **London, Ontario** Group No. **20284** Acct

Employee Name

Employee ID

Birthdate

Employee's Address

City

Province

Postal Code

Have you (or your dependent) any other coverage which would pay a benefit for this claim? ☐ Yes ☐ No

If 'yes', name of Employer and Insurance Co. ____ Health Only ☐ Dental Only ☐ Both ☐

If 'Yes', and claim is for a dependent child, please indicate spouse's date of birth ____

If co-ordination of benefits no longer applies, Termination Date ____

If claim is for child, indicate ☐ Full Time Student Date Enrolled ____ Date Completed ____ Handicapped ☐

| | FIRST NAME | SEX | DATE OF BIRTH | | | DATE EXPENSE INCURRED | NAME AND ADDRESS OF SUPLIER OR PHARMACY | DRUGS: NAME OR D.I.N. OTHER: TYPE OF EXPENSE | AMOUNT CHARGED |
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| | | | M | D | Y | | | | |
| EMPLOYEE | | | | | | | | | |
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| SPOUSE | | | | | | | | | |
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| UNMARRIED CHILDREN | | | | | | | | | |
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| | | | | | | | | **Total Charges** | |

I certify that the charges for the medical supplies which are listed above and for which the bills are attached were incurred by myself on account of myself or of one of my eligible family members upon the recommendation and approval of the attending physician and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my family members.

AUTHORIZATION: On behalf of myself and my elibible dependents, I authorize my employer and my group benefit provider, the Aetna Life Insurance Company of Canada and any of its affiliates or reinsurers to exchange the personal information contained on this form or any other benefit related personal information contained in their files now or in the future respecting me or any of my eligible dependents. I give my consent on the understanding that the information will be used soley for purposes of administration and management of my group benefit plan. This consent shall continue so long as I and my dependents are covered by, or are claiming benefits under the present group contract, or any modification, renewal or reinstatement thereof.

Date

Signature Of Employee

Telephone Number