Manulife Individual Insurance – Extended Health Care Claim

Important: Make sure you use the correct claim form for your plan.

Use this form for individual insurance plans **only**. If you are part of a Manulife group benefits plan, use the Manulife Group Benefits Extended Health Care (EHC) claim form GL3576 to submit your claim. Any individual insurance plan claims that are not submitted using this claim form CM5000 will be returned to you and **will not be processed**.

Make sure you attached the original receipts for all expenses. Original receipts will not be returned. Please keep a copy for your records. This form is to be completed by the insured unless indicated otherwise.

1 Insured information

Plan number _____ Identification number _____

Insured name (first, middle initial, last) _____

Date of birth (dd/mmm/yyyy) _____ Phone number ( ) _____

Insured address (number, street, suite/apt.) _____

Your explanation of benefits will be sent to the address on file. If you have moved or your address is different from what is on this form, update your information at **manulife.ca/secureserve** to avoid payment delays.

City/Town _____ Province/State _____ Postal code/Zip Code _____

2 Faster payments

Manulife is going digital - start benefiting now! Get your claims paid quickly and save time in the future.

Visit **manulife.ca/secureserve** to sign up for direct deposit, online claims, update your payment information, view your benefit details, and more.

3 Workers' compensation

Are any of the expenses associated with a work-related incident AND eligible for workers' compensation benefits? ◯ Yes ◯ No

If *Yes*, submit these expenses to your provincial workers' compensation board.

4 Coordination of benefits

Are you, your spouse, or dependants covered under any other plan for these expenses? ◯ Yes ◯ No

If *Yes*, make sure that you make a copy of your receipts to send to the other plan. If this is your first claim, or if information has changed, please provide the following:

Spouse's date of birth (dd/mmm/yyyy) _____ Name of spouse's insurance company _____

Spouse's plan number _____ Identification number _____

If we are your secondary carrier and you are submitting the balance of claim to us, make sure you attach copies of your receipts to this claim form. Also include the explanation of benefits from the other carrier that shows how much they paid. You cannot coordinate benefits or seek reimbursement with your Manulife Health Spending Account. See your cardholder agreement for complete terms and conditions.

5 Patient information

Complete for all expenses. Use one line per patient.

Patient's name	Date of birth (dd/mmm/yyyy) (First claim only)	Relationship to plan member (First claim only)

6 Prescription drugs

- Include your prescription drug receipts with this form.
- All receipts must contain the drug identification number (DIN) and the name of the prescription drug.
- You don't need to list this information on this form.

7 Practitioner/ Paramedical

(e.g. chiropractor, massage therapist, physiotherapist, etc.)

Make sure you attach an **itemized statement** or receipt that includes:

- patient name
- name of practitioner
- type of practitioner
- date of service
- length of visit
- charge for treatment
- date last paid by provincial plan (if applicable)
- licence and/or registration number

For psychotherapy claims, indicate the type of visit (individual, group, family, marriage, etc.) on your receipt.

8 Medical equipment and appliances

You **must** submit a prior authorization request and a written recommendation from a physician or nurse practitioner for the following items: hearing aids, orthotics, prosthetic appliances, medical equipment and supplies. Complete the Prior authorization for homecare, hearing aids, nursing, orthotics, prosthetic appliances, medical equipment, and medical supplies, **CM5006** in full and attach all requested information. We will not accept or process estimates or requests for third party assignment of benefits that are attached to this claim form. **Do not** register for, purchase, or submit claims for these devices and/or supplies that cost more than $300 until you receive information from us about whether your request has been approved or declined. Make sure you attach a copy of the prior-approval decision from Manulife when you submit your claim to us for reimbursement.

Name of item being claimed (include type/model/brand name): _____ Model/Serial number (if applicable) _____

Activities the item will be used for: _____

8 Medical equipment and appliances (continued)

Have you received a written recommendation of prescription for this device from a physician or nurse practitioner? ◯ Yes ◯ No

If *No*, please explain: _____

Duration equipment is required: **From:** Date (dd/mmm/yyyy) _____ **To:** Date (dd/mmm/yyyy) _____

Has rental equipment been returned (if applicable)? ◯ Yes ◯ No

Is the expense for your hearing aid(s), orthotics, prosthetic appliance(s), medical equipment, or medical supplies greater than $300? ◯ Yes ◯ No

If *Yes*, **before you made your purchase**, did you submit a prior authorization request to us that included all of the following? ◯ Yes ◯ No

Written recommendation/prescription from a physician or nurse practitioner, diagnosis and a copy of the statement from any provincial or territorial funding plan

If *No*, please explain: _____

We will not pay claims for hearing aids, orthotics, prosthetic appliances, medical equipment, and medical supplies over $300 that did not receive prior authorization.

9 Vision care

Make sure you attach an itemized statement or receipt that includes:

- patient name
- cost of contact lenses
- cost of glasses
- cost of laser surgery
- dispensing fee
- cost of eye exam
- date of eye exam
- cost of tinting
- date dispensed
- date last paid by Government Health Insurance Plan (GHIP) or GHIP plan maximum reached (if applicable)

10 Email address

By providing your email address, you will receive an email notification once your claim has been received and processed, including a link to **manulife.ca/secureserve** where you sign up for direct deposit, online claims, and view your benefit details.

Complete **only** when providing new or updated information.

Email address (Please print clearly)

11 Claims confirmation

Total amount of all receipts submitted: $_____

Note: You must include the **original receipts** for all expenses

12 Authorization and consent

By submitting a claim to Manulife, I confirm that I understand and agree to all of the following:

I certify that the information provided for the claim(s) being submitted is true, accurate, and complete and that I, my spouse or co-applicant and/or my dependents have received all goods or services or qualify for benefits as claimed. **I understand and acknowledge** that submission of a claim determined by Manulife to be false or misrepresented may result in coverage being rescinded by Manulife without further notice. **I understand and acknowledge** that Manulife may refer any claims it has determined were falsely submitted to law enforcement authorities for possible prosecution and may pursue the recovery of any money obtained improperly through false claim submission. **I also agree** to refund any monies or overpayments that I may owe to Manulife in accordance with the provisions of my coverage and **I authorize** Manulife to deduct such monies from my future claims. **I authorize** any person or organization with information about me or my family members to collect, use, maintain, and exchange this information with each other and with Manulife or Manulife's service providers to administer my plan, audit or assess my claims. This includes medical and health professionals, facilities, providers, regulatory bodies, insurers, investigators, and administrators of other benefits programs. **I understand and acknowledge** that I must submit prior authorization with a written recommendation from the prescribing physician or nurse practitioner, including diagnosis, and a copy of the provincial plan statement and/or completed a prior authorization form prior to purchasing and submitting claims for homecare, hearing aids, nursing, orthotics, prosthetic appliances, medical equipment, and medical supplies greater than $300. **I also acknowledge** that my claim may not be paid if I don't submit a prior authorization request to Manulife for items requiring prior authorization. **I agree** that I acknowledge all exclusions in my contract, including for benefits not payable for hearing aids, orthotics, prosthetic appliances, medical equipment, and medical supplies greater than Manulife guidelines. **I also agree** that I acknowledge that benefits are not payable for items that Manulife deems to be greater than usual, reasonable, and customary, or charges for devices that don't appear on Manulife's list of approved devices. **I also agree** that I acknowledge that benefits are not payable for charges for duplicate or replacement hearing aids, orthotics, prosthetic appliances, medical equipment, and medical supplies that are outside Manulife's guidelines for replacement. **I agree** that a photocopy, facsimile, or electronic version of this authorization shall be as valid as the original. If applicable, **I authorize** Manulife to use the email address provided as a means of communication with me related to my Individual Insurance health care coverage. **I agree** that Manulife is not liable for damages which I may have incur as a result of interception by a third party or an email transmission sent by Manulife or by me pursuant to this authorization. **I agree** that should the email address identified on this form change, I am responsible for updating the email address maintained by Manulife. **I understand** that if I do not wish to receive emails from Manulife. I can unsubscribe, remove my email address online or contact our contact centre at 1-800-268-3763 to have my email address removed.

Please Sign here - Your claim will not be processed without your original signature. Digital signature is not valid.

Signature of insured ✘ _____ Date signed (dd/mmm/yyyy) _____

13 Mailing instructions

Please mail your completed claim form, original receipts, and prior authorization approval notice for hearing aids, orthotics, prosthetic appliances, medical equipment, and medical supplies exceeding $300 (if applicable) to:

Manulife Individual Insurance Health Claims
P.O. Box 670, Stn Waterloo, Waterloo, ON N2J 4B8

14 Statement of confidentiality

The specific and detailed information requested on this form is required to process the insured person's claim request. To protect the confidentiality of this information, The Manufacturers Life Insurance Company (Manulife) will establish a financial services file. Information in this file will be used to process the application, offer and administer services, and process claims. Access to this file will be restricted to those Manulife employees, mandataries, and administrators who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations, and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, PO Box 1602, Del. Stn 500-4-A, Waterloo, Ontario N2J 4C6. A copy of our privacy policy is available on **manulife.ca.**

The Manufacturers Life Insurance Company (Manulife)

PRINT RESET

Accessible formats and communication supports are available upon request. Visit **manulife.ca/accessibility** for more information.