STANDARD LIFE

Emergis

GROUP LIFE & HEALTH

Drug Claim Reimbursement Form

INSTRUCTIONS FOR THE PARTICIPANT

1. **Please do not submit a drug claim until you have received your Assure Card™.** The issuance of your card will confirm your eligibility and allow the processing of your claim.
2. Please attach all original receipts and keep copies for your own records.
3. Explanation of Benefits statements and copies of your receipts are sufficient for income tax and benefit coordination purposes (see section III below).
4. **Please address any inquiries to our Info Line at 1 800 499-4415.**

I Participant information

Policyholder name		
Participant surname	Given name	Initials
Main residence address *(no., street)*		Apt.
City	Province	Postal code
Assure Card™ I.D. no.	**2 0**	

II Claimant information

Claimant surname and given name	Claimant code[1]	Date of birth *YYYY / MM / DD*	Number of receipts	Total amount
		/ /		
		/ /		
		/ /		

[1]**Claimant Code:** 1 = Participant; 2 = Spouse; 3 = Dependent childen; 4* = Dependent children (having reached the age limit); 5 = Permanently disabled children

** Claims for a child who has reached the first age limit specified in the contract (claimant code 4) will be accepted only if satisfactory confirmation of school attendance has been received by Standard Life. Please contact Standard Life or your Plan Administrator for further information.*

III Coordination of benefits

Is your spouse covered for these expenses under another group insurance plan? ❑ Yes *(please provide details in section below)* ❑ No

Name of the insurance company			Policy no.
Certificate no.	Spouse's date of birth	*(YYYY / MM / DD)* / /	Spouse's coverage ❑ Single ❑ Family

IV Out of country claim

If this claim is for medication purchased outside of Canada, please provide the following information:

Country where drugs were purchased	Currency of country where drugs were purchased

V Authorization

I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, insurer, employer, or any other person or organization in possession of information concerning myself to release to The Standard Life Assurance Company of Canada and Emergis Inc. all medical, financial, or other information deemed relevant by Standard Life and Emergis Inc., for the assessment of my claim.

I authorize The Standard Life Assurance Company of Canada and Emergis Inc. to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Standard Life and Emergis Inc. or their authorized agents use the information provided in this form and prior claims under the same plan (if relevant) for the management of my claim and for statistical reports.

I confirm being authorized by my dependents to act on their behalf for their expenses submitted in this claim.

I consent to the use of my Social Insurance Number as my certificate number, and understand that it is my responsibility to contact my employer/plan administrator if I prefer to use another identification number.

I certify that the information contained in this form is true, correct and complete and that the amounts shown on both the receipts and the form truly reflect the amounts actually paid for the medical care. In the event of any false statement, Standard Life and Assure Health will automatically reject this claim in all or in part.

A photocopy of this authorization is valid as the original.

Participant signature	Date *(YYYY / MM / DD)* / /

To avoid any delay in the processing of your claim, please provide all required information and submit this form to:

Emergis Inc.
Claims Payment Department
5090 Explorer Drive, Suite 1000
Mississauga (Ontario) L4W 4X6

GE9205C-01-2006 GL