STANDARD LIFE

GROUP LIFE & HEALTH

Medical and Paramedical Claim Form

CLAIMS DEPARTMENT

MONTRÉAL
P.O. BOX 4002 POSTAL STATION B
MONTRÉAL, QUÉBEC H3B 4M2

TORONTO
P.O. BOX 4105 POSTAL STATION A
TORONTO, ONTARIO M5W 2P4

IMPORTANT: Please print, ensure that all information is provided and SIGN this form in order to avoid claims processing delays.
If you need assistance in completing this form, do not hesitate to contact us at 1 800 499-4415.

I Participant Statement

(complete this section to ensure quick identification)

Policyholder name		Policy no.	Certificate no.
Participant surname	Given name		Initial
Main residence address *(no., street)*			Apt.
City	Province		Postal code
Language: ❑ English ❑ French	Sex: ❑ M ❑ F	Telephone no. *(day)* ( )	Date of birth *(YYYY / MM / DD)*

II Dependents

(complete this section the first time you submit a claim for a dependent child or spouse or whenever there is a change)

Spouse surname	Given name	Date of birth *(YYYY / MM / DD)*

Children

Complete name	Date of birth *(YYYY / MM / DD)*	Sex M F	Full-time student*	Confirmation of school attendance Name of educational institution and attendance period
Surname / Given name	/ /	❑ ❑	❑	Name Start *(YYYY / MM / DD)* End
Surname / Given name	/ /	❑ ❑	❑	Name Start *(YYYY / MM / DD)* End
Surname / Given name	/ /	❑ ❑	❑	Name Start *(YYYY / MM / DD)* End
Surname / Given name	/ /	❑ ❑	❑	Name Start *(YYYY / MM / DD)* End

* *Student's status: The Standard Life Assurance Company of Canada reserves the right to confirm student status with the educational institution.*
Disabled child: If a child is over the dependent child age limit under your contract and was permanently disabled while considered a covered dependent, please submit the form "Application for Total and Permanent Disability Status for a Dependent Child" GE10152 completed by you and the physician.

III Coordination of benefits

(complete this section if any expenses you are claiming for are covered by another plan)

Name of your spouse's group insurer		Policy no.	Certificate no.
Coverage: Health Insurance ❑ Single ❑ Family		Dental Care ❑ Single ❑ Family	
Effective date of coordination of benefits *(YYYY / MM / DD)*		Cancellation date of coordination of benefits *(if applicable)* *(YYYY / MM / DD)*	

Claiming instructions: for his/her expenses, your spouse must claim first to his/her insurer. Children's claims must be submitted to the insurer of the parent whose date of birth occurs first in the calendar year. If claim was already processed by another insurer, please submit a copy of their explanation of benefits and copies of receipts.

Please see reverse >>

If you do not need the following section, please detach it.

DIRECT DEPOSIT IS THE PREFERRED METHOD OF PAYMENT BY STANDARD LIFE. IF YOU DO NOT ALREADY USE IT, PLEASE COMPLETE THIS SECTION

Direct deposit - authorization

❑ 1st request ❑ Modification		Policy no.	Certificate no.
Participant surname	Given name		Telephone no. *(day)* ( )
Financial institution name	Financial institution address		
Type of bank account: ❑ Chequing *(please attach a personalized void cheque)* ❑ Savings *(please provide your banking information in the adjacent section)*	Branch no.	Institution no.	Account no.

I authorize Standard Life to credit all my benefit payments to the account mentioned on this form. I certify that the information provided on this form is accurate, and I agree to inform Standard Life of any subsequent changes. I accept that this agreement may be cancelled at any time by either Standard Life or myself, in writing or verbally.

Participant signature	Date *(YYYY / MM / DD)* / /	Account holder signature *(if other than participant)*	Date *(YYYY / MM / DD)* / /
For Standard Life use only			Received *(YYYY / MM / DD)* / /