Manulife Financial

For your future™

Group Benefits
Medical Travel Referral Expense

- *Please complete all requested information and attach original receipts to the claim form.*
- *Incomplete forms, or those without receipts cannot be processed for payment.*

1 Plan member information

To be completed by the plan member.

Policy number	Plan member ID number	Plan sponsor/employer
83710		**College of New Caledonia**

Plan member name (last, first, middle initial)	Date of birth (dd/mmm/yyyy)

Plan member address (number, street and apartment)	City	Province	Postal code

Are these expenses eligible for coverage under any type of workers' compensation board?	◯ Yes ◯ No
Are expenses related to an automobile accident?	◯ Yes ◯ No
Are you seeking damages from a third party? If "Yes," please provide name of the employer and other insurance company	◯ Yes ◯ No
Are expenses related to a dental claim? (Dental related travel expenses are only eligible when referred by a licensed doctor (MD) and/or when hospitalization for dental treatment is required.)	◯ Yes ◯ No
Are you, your spouse or dependants covered under any other plan for the expenses being claimed?	◯ Yes ◯ No

If "Yes," please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier. 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 contract number	Spouse's plan member certificate number

2 Expense information

To be completed by the plan member.

Please complete all requested information and attach original receipts to the claim form. Incomplete forms, or those without receipts cannot be processed for payment.

Transportation is payable (with receipts) over and above eligible expenses.

Family member name (last, first, middle initial)	Relationship	Date of birth (dd/mmm/yyyy)

Date of expense (dd/mmm/yyyy)	Description (transportation, meals, accommodation)	Charge	Name/location of treating physician

Coverage limits
$125/day – 50 days per year

Meal allowance
Provide breakdown of expenses for breakfast, lunch and/or dinner for each individual and attendant (if required).

1a. Indicate the location of your HOME CAMPUS (assigned campus location) _____

b. Indicate mileage travelled from HOME CAMPUS to locale where treatment is rendered _____ kms

2a. Indicate mode of transportation ◯ Scheduled air ◯ Rail ◯ Bus ◯ Ferry ◯ Taxi ◯ Auto

b. If by auto, indicate mileage travelled from place of residence to locale where treatment is rendered _____ kms

3. Was an attendant required to accompany patient? ◯ Yes ◯ No

4. Were overnight accommodations required? ◯ Yes ◯ No
If "Yes," indicate type of facility (hotel/motel/Ronald McDonald House, etc.) | Length of stay (days)

3 Authorization for medical travel

To be completed by the plan member.

If required, attach referral or provide details.

1. Is this the first referral for services not available locally? ◯ Yes ◯ No
   If "No", proceed to question 2 OR If "Yes", proceed to section 4
2. Is this a revisit based on a referral made to this specialist within the last 12 months? ◯ Yes ◯ No
   If "No", a new physician's referral is required. Please attach a new physician's referral or have your attending physician complete section 4 if the patient is being referred to a different specialist OR if the last referral to the same specialist was more than 12 months ago.
   If "Yes", provide the date of the last visit _____ (dd/mmm/yyyy)

4 Initial referrals and re-referrals after 12 months

To be completed by the referring physician.

This section MUST be completed for initial referrals and re-referrals after 12 months. Completion of this section is NOT required if patient has been referred to the same consulting physician within the past 12 months.

1. Confirm the patient is being referred for medically necessary services and provide reason for referral.

Referring physician's name	Location
Signature of referring physician	Date(s) of referral treatment(s) (dd/mmm/yyyy)

5 Attendant referrals

To be completed by the referring physician.

Completion of this section is required where a patient is 18 years of age or older and is medically unfit to travel unaccompanied. For patients under 18 years of age, it will be assumed that the patient must be accompanied and this section may be omitted.

1. Is the patient medically fit to travel unaccompanied? ◯ Yes ◯ No
2. If the patient is 18 years of age or older, please provide reason it is medically necessary for the patient to travel accompanied.

Referring physician's name	Location
Signature of referring physician	Date(s) of referral treatment(s) (dd/mmm/yyyy)

6 Consulting physician or authorized representative

This section must be completed for ALL claims.

Consulting physician's name	Location	Date(s) patient seen (dd/mmm/yyyy)
Signature of consulting physician or authorized representative	Title of authorized representative*	

*Required if form has not been signed by the consulting physician.

7 Declaration and authorization

If you have questions, please call your B.C. Colleges & Institutions benefit helpline at 1-800-575-2200.

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/planmember, or from my Plan Sponsor.

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

You must sign and date in the space provided below. Failure to sign the claim will result in your claim being returned for signature.

Signature of plan member	Date (dd/mmm/yyyy)

8 Mailing instructions

Please send the completed form and receipts to:

Manulife Financial Group Benefits
Health Claims
PO BOX 1616 STN WATERLOO
WATERLOO ON N2J 0C8