THE Great-West Life ASSURANCE COMPANY

Great-West Life your Benefits Solutions People

Please complete Schedule A and Schedule B (reverse) and return this form to Great-West Life as soon as possible to ensure prompt assessment of your claim. These forms will be returned to the claimant if not fully completed.

Schedule "A" Agreement

BETWEEN: _____ **("the Resident")**

AND: THE GREAT-WEST LIFE ASSURANCE COMPANY ("the Insurer")

AND: HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF ALBERTA AS REPRESENTED BY THE MINISTER OF HEALTH ("the Minister")

WHEREAS the Resident is eligible for Health Services and as such may receive payment for Health Services from the Minister.

And WHEREAS the Resident is under an obligation pursuant to a contract with the Insurer to remit to the Insurer all such payments received for Health Services from the Minister.

And WHEREAS the Resident may be indebted to the Minister for health insurance premiums under the Health Insurance Premium Act, R.S.A. 1980, c.H-5 (as amended).

IN CONSIDERATION of the undertakings herein, the parties agree:

1. Subject to clause 2, the Resident assigns to the Insurer all sums of money that shall be owing to the Resident by the Minister for the above noted contract. The Minister is authorized to pay all such sums directly to the Insurer, with payment of any such sum to be sufficient discharge to the Minister of and from any indebtedness in that amount to the Resident, his heirs, executors, or administrators.

2. Prior to any payment being made by the Minister to the Insurer, the Minister is authorized by the Resident to deduct from the sums payable to the Insurer, any amount for which the Resident is indebted to the Minister for arrears in health insurance premiums owing under the Health Insurance Premiums Act.

3. This agreement is effective from _____ to _____
(Date of first occurrence of claim to last occurrence)

DATED this _____ *day of* _____ *year* _____

Signature of Resident _____

WITNESS _____ *Signature of Insurer* _____

_____ _____
Great-West Life I.D./Cert. Number Great-West Life Plan Number/Employer

M5503-5/10

Schedule "B"

AUTHORIZATION TO PROVIDE HEALTH INFORMATION

I, _____
(Resident)

(OR I _____
(if patient is a minor dependent)

Parent/Guardian of _____ *a minor)*

hereby consent to and authorize the Ministry of Health to furnish to any representative of *The Great-West Life Assurance Company* such records and information as may be disclosed in accordance with the Alberta Health Care Insurance Act, regarding claims for Health Services incurred while I had insurance coverage from _____ *(First Date of Claim)*, regardless of lapsed time.

DATED this _____ *day of* _____ *year* _____

Alberta Personal Health Card Number: _____

Signature: _____

Address: _____

_____

_____

Telephone Number: _____

Clear