

**PRESCRIPTION DRUG CLAIM FORM**  
For  
**Manitoba International Students Health Insurance Plan**  
Group Policy No. 42074

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**SECTION A:** Complete Insured Student Information

Name of Insured Student: \_\_\_\_\_

Health Plan Identification Number: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

Insured Status: Please check one box.       Single       Family

(Complete **Section B** if this claim includes drug purchases for eligible dependents.)

Manitoba Address: \_\_\_\_\_

City or Town: \_\_\_\_\_ Province: \_\_\_\_\_ Manitoba

Postal Code: \_\_\_\_\_

Institution (School): \_\_\_\_\_ Division Number: \_\_\_\_\_

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**SECTION B:** Complete Dependent Information

	<b>Name of Dependent</b>	<b>Date of Birth</b>	<b>Relationship to Insured Student</b>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

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**SECTION C:** Attach Receipts and Mail

Total dollar value of receipts attached? \$ \_\_\_\_\_

Attach "Official Pharmacare Receipts" for one policy year only. A policy year starts September 1<sup>st</sup> and ends August 31<sup>st</sup>.

Date: \_\_\_\_\_ Signature of Insured Student: \_\_\_\_\_

**Mail the Completed Claim Form and Attached Receipts to:**  
**GREAT-WEST LIFE HEALTH & DENTAL BENEFITS**  
**P.O. BOX 3050**  
**WINNIPEG MB R3C 0E6**

**All claim inquiries should be directed to Great-West Life**  
**toll free at 1.800.957.9777**  
**Outside Canada or US call collect:**  
**204.946.1190**