

SCHEDULE A

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____ (or, I _____ parent/guardian of
(patient's name) _____, a minor) hereby consent to and authorize Manitoba Health to furnish to any representative of Great-West Life, claim and payment information in Manitoba health's possession in respect of claims for Medical Services incurred for which I had insurance coverage from _____, including physician/hospital name, date of service, and services provided (in-patient, out-patient, physiotherapy, visit, procedure, x-ray or laboratory services).
(indicate trip dates)

Schedule "B"

ASSIGNMENT OF PAYMENT DUE TO REGISTRANT UNDER THE HEALTH SERVICES INSURANCE ACT

I, _____ (or, _____ parent/guardian of
(patient's name) _____, a minor) hereby direct Manitoba Health to forward payment to Great-West Life for any claims for benefits under the Health Services Insurance Act submitted by Great-West Life assurance in respect of medical and hospital services provided outside Canada.

DATED this _____ day of _____ 20 ____ .

Patient's Manitoba Health Registration Number

Patient's Signature

Address

Patient's Personal Health Identification Number

Telephone