MANITOBA SAFEWAY/UFCW LOCAL 832
HEALTH & WELFARE (PLAN 2)

MEDICAL EXPENSE CLAIM FORM

INSTRUCTIONS: **YOU SHOULD ACCUMULATE AT LEAST $50 IN EXPENSES BEFORE YOU SUBMIT A CLAIM.** Attach the receipts for all expenses. **Note:** Receipts are part of our records and will not be returned. Therefore please retain, for Income Tax purposes, the cheque stub that is attached to your cheque. **If you have coverage under another plan, your claim must be submitted to that plan first and proof of what they paid must be attached to this claim.**

Prescription Drugs: Attach all original Pharmacare receipts. Claims ***must be submitted*** to the Administrator **by the January 31st** immediately following the calendar year (January 1 to December 31) during which the expense was incurred.
Each year, remember to attach to your first claim after April 1st, a copy of your new Pharmacare Deductible Letter.

Other Expenses: Claims *must be submitted* to the Administrator by the January 31st immediately following the calendar year (January 1 to December 31) during which the expense was incurred.

IMPORTANT: Please answer all questions and sign the reverse side of this form. This claim will be returned to you if it is incomplete or contains errors.

MEMBER'S STATEMENT

Member's Name _____ S.I.N. _____
(Last) (First)

Address _____
(Number and Street) (City) (Province) (Postal Code)

Phone Number _____

TOTAL AMOUNT CLAIMED → → → → **$** _____

Are you eligible for Medical or Vision Care Benefits under any other plan? *(See "Steps To Follow - Co-ordination Between Two Plans" on the reverse of this form, when benefits are provided under more than one Plan)*

☐ No
☐ Yes. If "Yes" provide: Name of Insurance Company and Policy Number _____

Name of family member insured: _____

Relationship to you: _____

Is any of the treatment required as a result of an injury? ☐ Yes ☐ No
Is the injury due to a motor vehicle accident? ☐ No ☐ Yes (If Yes, has a claim been made to MPIC?) ☐ Yes ☐ No

Is any of the treatment required as a result of an illness/injury that is work related? ☐ Yes ☐ No
If Yes, has a claim been made to Workers' Compensation? ☐ Yes ☐ No

Any Member making a false claim may have his/her eligibility discontinued and/or the Trustees may commence such legal action as they deem necessary and appropriate in the circumstances.

Please Turn Over for Certification/Consent and Signature

CO-ORDINATION BETWEEN TWO PLANS

If you are covered under another plan, which provides the same benefits for which you are claiming, you must submit a claim for your expenses to the other plan first. When you receive the details of the payment made, attach a copy of this information to your claim, for reimbursement of any unpaid balance.

CERTIFICATION AND CONSENT

I understand that it is an offense to make a false or misleading statement regarding the personal and claims information provided herein and declare that the information is true, correct and complete to the best of my knowledge and belief.

I certify that the charges for the services and/or supplies which are identified on the reverse side of this form, and for which receipts are attached, were incurred by me.

I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in strictest confidence and will only be used for the specified purpose.

I understand that my personal information as provided herein, as well as other personal information currently held or to be collected in the future, is required to: communicate with me; determine coverage and benefit entitlement; satisfy any reporting requirements of the provincial and federal governments; comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan.

I hereby authorize the Board of Trustees and the service agencies they employ to: collect, record, use, disclose and, if applicable, destroy my personal information. I understand that all personal information will be kept confidential and secure, and that it will only be used for the purposes identified herein. Also, I understand that I may review this information to ensure that it is up-to-date and that I may withhold or revoke my consent for its use, at any time. However, I realize that if I withhold or revoke my consent for its use, thereby limiting or restricting the ability to determine coverage and benefit entitlement, my participation in the Plan may be impaired or cancelled.

If I have coverage under another plan, I hereby authorize the Board of Trustees and the Plan administrator to disclose personal information about me, in order to determine coverage and benefit entitlement.

A photostatic copy of this authorization will be as valid as the original.

Signature of Member Date

Mail your completed form to:

MANITOBA SAFEWAY/UFCW LOCAL 832 HEALTH & WELFARE PLAN 2
3rd Floor, 880 Portage Avenue, Winnipeg, Manitoba R3G 0P1
Phone: 982-4177 (in Winnipeg) or 1-877-982-4177 (outside Winnipeg)