

MAJOR MEDICAL CLAIM FORM

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.

Please see reverse side for Certification and Consent

MEMBER'S STATEMENT

Member Name _____ S.I.N. _____

(First) (Last)

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

Phone Number _____ Date of Hire _____ Clock Number _____

I hereby certify that this claim is being made for expenses I incurred on behalf of:

						If Child age 18 or over							
Patient Name	Relationship to Member	Date of Birth			Does patient reside with you?		Full-Time Student?***		Student Number	Handi-capped?		Employed?	
		Year	Month	Day	Yes	No	Yes	No		Yes	No	Yes	No

*** If a full-time student please provide name of educational institution _____

Are you, or your dependents eligible for Major Medical 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 family member, relationship to you, name of other plan, Carrier and Policy Number):

Are any of your dependents employed at Western Glove? Yes No

If "Yes" provide name of family member and relationship to you _____

INSTRUCTIONS:

Vision Care (Member Only) - Please attach all receipts showing the date your eye examination was performed and/or the date the glasses/contact lenses were purchased and the amount paid.

Prescription Drugs (Member/Dependent) - Please attach only Official Pharmacare drug receipts. The receipts must be eligible under Pharmacare and total \$175 or more during a calendar year, to be eligible for reimbursement.

Hearing Aids (Member Only) - Please attach original receipts showing the date of purchase and the amount paid.

Chiropractic Treatment (Member Only) - Please attach original receipts showing the treatment date(s) and the amount paid.

Ambulance (Member/Dependent) - Please attach original receipts showing the date the service was provided and the amount paid.

Flu Shots (Member/Dependent) - Please attach original receipts showing the treatment date and the amount paid.

Please complete and return this form to:
 UFCW Local 832 Benefit Plan (Apparel Division)
 3rd Floor, 880 Portage Avenue, Winnipeg, Manitoba R3G 0P1

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, or on behalf of one of my dependents.

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 and that of my dependants who are under 18 years of age, as provided herein, as well as other personal information currently held or to be collected in the future, is required to: determine coverage and benefit entitlement; satisfy any reporting requirements of the provincial and federal governments; comply with civil and criminal law; determine future operating costs; 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 and that of my dependents who are under 18 years of age. 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 cancelled.

If I, or my dependents under 18 years of age, have coverage under another plan, I hereby authorize the Board of Trustees and the Plan administrator to disclose personal information about me, and such dependents, 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

Also, if an expense has been incurred on behalf of your Spouse, and is attached to this claim, please have your Spouse sign the following.

I hereby consent to the use of my personal information in the same manner as described above.

Signature of Spouse

Date

Also, if an expense has been incurred on behalf of a Dependent Child age 18 or over, and is attached to this claim, please have your Child sign the following.

I hereby consent to the use of my personal information in the same manner as described above.

Signature of Dependent Child Age 18 or over

Date

Any Member making a false claim may have future eligibility discontinued by the Trustees.