WORKERS UNITED CANADA BENEFITS TRUST FUND

SUPPLEMENTARY HEALTH STATEMENT OF EXPENSES

INSTRUCTIONS: Attach the bills and receipts for all expenses and itemize them by providing all the information requested.

Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our

cheque or explanation for Income Tax purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors.

					Ple	ase i	Print									
MEMBER'S S	TATEMENT															
PLAN NUMBER 458	DIVISION NO. N/A	MEMB	ER NA	ME												
SOCIAL INSURANCE NU	JMBER	<u>'</u>							DATE	OF BIF	RTH					
ADDRESS: NUMBER AND STREET TOV				TOWN PROVINCE POSTAL CODE PHONE # HOME:							WORK:					
COORDINATION OF BENEFITS											SEI		THIS	CLAIM		
Are you or any other member of your family entitled to benefits under any other plan? Yes $\ \square$ No $\ \square$												PBAS 61 International Blvd. Suite 110				
If "Yes", name the family member insured: Relationship to employee:													Toronto, Ontario M9W 6K4			
Name of other insurance company: Policy Number:										Phone: Local 416-674-3350 Toll Free1-800-461-4361						
Is any member of your Yes □ No □	our family (other tha	n yourself) ins	ured as	an emp	loye	ee un	der this p	olan?								
If "Yes" to either quite Is treatment require	d as the result of an	accident?	Yes □	No □	If	"Yes	", give da	ate, locatio	on and		Day	Mon		Year I:	.	
DEPENDENT	INFORMATIO	N									If	child	over 2	20 vea	ars	
	Patient Name Relationship to Member		Date of Bir							II-Time If Studen III-Time If Student?		nt, how Emplo			How many hrs worked per week?	
CLAIM DETA	ILS															
Patient Name			f Total Charge				Type Of Expense			OTHE	R EXPENSES Nature Of Ill			То	Total Charge	
		Receipts														
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			If addition	nal chaca	 ic =	9945	d attach a	eparate pag	10)							
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Please see reverse side for Certification And Consent.

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.

I certify that the charges for the medical 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 eligible dependents, on the recommendation and approval of an attending physician, and were required in connection with the treatment of an injury or illness suffered by me or one of my eligible 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 dependents 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: communicate with me; determine coverage and benefit entitlements; process claims for expenses incurred; 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 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 the information, referenced herein, for myself or my dependents, who are under 18 years of age, 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 entitlements, my participation in the Plan may be impaired or cancelled.

If I, or my dependents under 18 years of age, have coverage under another plan, I hereby authorize the Trustees to disclose personal information about me, and my dependents, in order to determine eligibility for coverage in the settlement of claims.

A photostatic copy of this authorization will be as valid as the original.							
Signature of Plan Member	Date						
If an expense has been incurred by your eligible spouse, and is attached to this claim, please have your spouse sign the following.							
I hereby consent to the collection, recording, use, disclosure and, if applicable, destruction of my personal information in the same manner as described above.							
Signature of Spouse	Date						
If an expense has been incurred by an eligible dependent child age 18 or older, and is attached to this claim, please have your child sign the following.							
I hereby consent to the collection, recording, use, disclosure and, if applicable, destruction of my personal information in the same manner as described above.							
Signature of Dependent Child Age 18 or Over	Date						