UNITED ASSOCIATION LOCAL 740
WELFARE TRUST FUND

GROUP HEALTH
CLAIM FORM

Member - complete this section. Please print.

1 Member's Name: _____ Date of Birth (Day / Month / Year) ____ / ____ / ____

2 Address: _____ CERT# | | | | | | | | | | |
Street

_____ Postal Code: _____
City Province

Phone Number: ( ) _____

3 If you are making a claim for a Dependent, please provide the following information:

Name	Date of Birth (Day Month Year)	Relationship (Spouse/Child)	Is Dependent Working? (Yes or No)	Is Dependent in School? (Yes or No)	If working, provide name of employer If in school provide name of institution

4 Are group health benefits payable from any other source? ☐ Yes ☐ No Name Source _____

5 Are any expenses due to sickness or injury arising out of any employment of the member or dependent? ☐ Yes ☐ No

If "yes", provide date and details _____

Is claim being made for any Workers' Compensation benefits? ☐ Yes ☐ No

6 Name and address of prescribing physician(s). _____

ORIGINAL RECEIPTS MUST BE ATTACHED TO THIS FORM

7 Total amount of this claim:

$ _____

I hereby certify that the above statements are true, accurate and complete to the best of my knowledge and belief. I understand that the Plan Administrator will use the information provided by me on this claim form strictly to process my claim. I hereby authorize the Plan Administrator to evaluate or investigate my claims and release my personal information (including health information) to qualified third parties solely for the purpose of conducting such evaluations or investigations, and only to the extent required for such purposes. I hereby authorize my union, physician or other health professionals, any medical or dental facility, any insurance company or government body, and any other person or institutions to release relevant information to the Plan Administrator solely for the purpose of processing this claim. A photocopy of this release shall be as valid as the original.

Member's signature _____ Date _____ 20 ____

Member - submit completed claim form and original receipts to:

Manion Wilkins and Associates
626-21 Four Seasons Place
Toronto, ON
M9B 0A5