ONTARIO UFCW
HEALTH & WELFARE FUND

OUFCW Health & Welfare Fund
Suite 110 - 61 International Blvd.
Toronto, ON M9W 6K4

Toll Free: (800) 461-4361
Email: ontufcwclaims@pbas.ca

STATEMENT OF EXPENSES FOR HEALTH CARE BENEFITS

To be considered an eligible expense, claims must be received within 18 months from the date expense was incurred or 6 months from the date your plan terminated, using the date of service or the date supplies were purchased. Your claim form must be completed in full, with itemized expenses, and receipts attached. Please note: drug receipts, other than those required for government drug plans, will not be returned. Please retain copies or your explanation of benefits for income tax purposes.

Members Statement	Certificate Number	Telephone Number
OUFCW Health & Welfare Fund		

Member Name	Date of Birth (D M Y)	Email Address

Mailing Address No. and Street	City	Province	Postal Code

Coordination of Benefits

Do you have another plan that provides Benefits for you or dependants? Yes ☐ No ☐

If yes, indicate:	**Name of the Insurance Provider**			**Policy Number**
	Type of Coverage	**Health Only**	**Dental Only**	**Both**
	Policyholder's Name (if applicable):			**Date of Birth:**

Is any member of your family (other than yourself) a member of this Plan? Yes ☐ No ☐
If yes, and the answer is a dependant child, please provide your spouse's date of birth:
Is this claim for a dependant child over the age of 20, please confirm:
Is the child a full-time student, residing with you? Yes ☐ No ☐
Is the child employed? Yes ☐ No ☐ If yes, How many hours worked per week:

Is treatment required as the result of an accident? Yes ☐ No ☐ If Yes, please attach details, including date and location of accident.

Is a claim being made for Worker's Compensation Benefits through WSIB? Yes ☐ No ☐

Patient Information				Drug Expenses		Other Expenses	
Patient Name	Date of Birth D	M	Y	DIN or Drug Name	Total Charge	Type Of Expense	Total Charge
			Total:		$0.00	Total:	$0.00

Personal information collected will be used for the purposes of assessing your claim and administering the Benefit Plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices, contact the Administrator at the address above.

By signing this Claim Form, I authorize the PBAS Group to exchange my personal information and the information provided on behalf of my dependants, with other insurance or reinsurance companies, administrators, or health/dental care providers, when necessary to adjudicate my claim(s). I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information provided is true, correct, and complete, to the best of my knowledge. I acknowledge that a photostatic copy of this form will be as valid as the original.

Signature of Member _____ Date _____