

Ontario UFCW ELHT Employee Life & Health Trust 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						Ontificate Namehou			Telephone Number	
		Ce	rtificate Number		relephone	Number				
Ontario UFCW ELHT Benefit Plan										
Member Name				Date of Birth			ail Address			
			D	MY						
							D (10 1			
Mailing Address			City		Province Postal Code					
Coordination of Benefits										
Do you have another plan that provides Benefits for you or dependants? Yes No										
	Name of the Insurance P	rovid	Policy Number							
If yes, indicate:	Type of Coverage	H	lealt	h On	ly	Dent	Both			
	Policyholder's Name (if a	applic	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.										on 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		DIN or Drug N	Name	Total Charge	Type Of Expen	Of Expense	e Total Charge
		D	М	Υ						
Total:									Total:	
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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.

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Signature of Member	•	Date