MANITOBA SAFEWAY/UFCW LOCAL 832 HEALTH & WELFARE PLANS

MAJOR MEDICAL CLAIM FORM - AGROPUR

INSTRUCTIONS:

- Answer all questions and sign the reverse side of this form. This claim will be returned to you if it is incomplete.
- Attach receipts for all expenses. *Note:* Receipts will not be returned; please keep copies for your records.
- **Prescription Drugs:** Attach all original Pharmacare receipts. Each year, remember to attach to your first claim after April 1st, a copy of your new Pharmacare Deductible Letter. Claims must be submitted to the Administrator by the June 30th immediately following the Pharmacare Plan Year (April 1 to March 31) during which the expense was incurred.
- **Expenses other than Prescription Drugs:** Claims must be submitted to the Administrator by the March 31st immediately following the calendar year (January 1 to December 31) during which the expense was incurred.
- Please keep our Explanation Of Benefits attached to your cheque for co-ordination of benefits with another plan and for Income Tax purposes.

PLEASE SEE REVERSE SIDE FOR CERTIFICATION AND CONSENT AND REQUIRED SIGNATURES

MEMBER'S STATEMENT

Member's Name _____ S.I.N. _____
(Last) (First)

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

Phone Number _____

TOTAL AMOUNT YOU ARE CLAIMING (Total Amount Of All Attached Receipts) _____

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

						If Child age 21 or over			
Patient Name	Relationship to Member	Date of Birth Year	Month	Day	Does patient reside with you? Yes / No	Full-Time Student? ** Yes / No	Student Number	Handi-capped? Yes / No	Employed? If Yes, how many hours per week? Yes / No

****IF A FULL-TIME STUDENT PLEASE PROVIDE NAME OF EDUCATIONAL INSTITUTION** _____

ARE YOU, OR YOUR DEPENDANTS, ELIGIBLE FOR MEDICAL BENEFITS UNDER ANOTHER PLAN? (See reverse of this form for instructions)

☐ No
☐ Yes. If "Yes" provide name of family member, relationship to you, name of other plan, Insurance Company and Policy Number, below:

_____

ARE ANY OF YOUR DEPENDANTS EMPLOYED BY SAFEWAY, CO-OP, CANADA BREAD OR AGROPUR? ☐ No ☐ Yes
If Yes, provide name of family member , relationship to you and name of employer _____

ARE ANY OF THE EXPENSES THE RESULT OF AN INJURY? ☐ No ☐ Yes. If Yes, how did the injury happen? _____

_____

- If the injury is due to a motor vehicle accident has a claim been made to MPI? ☐ Yes ☐ No
- If the injury happened at work, has a claim been made to Workers' Compensation? ☐ Yes ☐ No

ANY MEMBER MAKING A FALSE CLAIM MAY HAVE HIS/HER ELIGIBILITY DISCONTINUED AND/OR THE TRUSTEES MAY COMMENCE SUCH LEGAL ACTION AS THEY DEEM NECESSARY AND APPROPRIATE IN THE CIRCUMSTANCES.

Please complete and return this form to:
MANITOBA SAFEWAY/UFCW LOCAL 832 HEALTH & WELFARE PLANS
3rd Floor, 880 Portage Avenue, Winnipeg, Manitoba R3G 0P1

CO-ORDINATION BETWEEN TWO PLANS

If you and your Spouse are both employees of Employers who participate in Plan 1, and you are both eligible for benefits under Plan 1, the Administrator will automatically co-ordinate the benefits between your file and your Spouse's file if you indicated this on the reverse side of this form.

If you and your Spouse are members of 2 different plans, which provide the same benefits for which you are claiming, the steps are as follows.

Step 1 - submit a claim for your expenses to this Plan for reimbursement. The payment details will be sent to you with your payment. Submit this information to your Spouse's plan for reimbursement of any unpaid balance.

Step 2 - your Spouse must submit a claim for his/her expenses to his/her plan for reimbursement. When he/she receives details of the payment made, submit a copy of this information to this Plan for reimbursement of any unpaid balance.

Step 3 - claims for your children should **first** be submitted to the plan of the parent whose birth month is the earlier in the year, **then** to the other plan.

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 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 entitlement; 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 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 impaired or 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 any of the expenses claimed were incurred by your Spouse, or a Dependent Child age 18 or over, please have them sign the following consent:

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 _____

Signature of Dependent Child Age 18 or over _____ Date _____

Signature of Dependent Child Age 18 or over _____ Date _____