HYLIFE FOODS/UFCW LOCAL NO. 832 BENEFIT PLAN

3RD FLOOR, 880 PORTAGE AVENUE, WINNIPEG, MANITOBA R3G 0P1
PHONE: 1-877-982-4171 FAX: 982-6080

ADMINISTRATOR'S USE: CLAIM No.

	UNIQUE NO.	SPECIALIST
PATIENT NAME	DENTIST / DENTURIST	
ADDRESS		
CITY PROV. POSTAL CODE	PHONE NO.	

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST/DENTURIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

_____

SIGNATURE OF MEMBER

PART 1 - DENTIST'S CERTIFICATION

THIS STATEMENT IS : ☐ A PRE-DETERMINATION ONLY
NUMBER OF X-RAYS SUBMITTED: _____

☐ AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED E. & O.E.

1. IS ANY TREATMENT FOR ORTHODONTIC PURPOSES? ☐ YES ☐ NO
2. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO

IF NO, GIVE DATE OF PRIOR PLACEMENT: _____

_____
DENTIST/DENTURIST SIGNATURE

DATE OF SERVICE DAY	MO.	YR.	TOOTH CODE	PROCEDURE CODE					TOOTH SURFACES	DENTIST'S FEE	LAB CHARGES	TOTAL CHARGES	

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE

TOTAL FEE SUBMITTED

PART 2 - MEMBER'S STATEMENT

1 MEMBER'S NAME _____

2. SOCIAL INSURANCE NUMBER _____

3. MEMBER'S DATE OF BIRTH _____

4. SPOUSE'S DATE OF BIRTH _____

PART 3 - PATIENT INFORMATION

1. PATIENT RELATIONSHIP TO MEMBER _____
2. PATIENT'S DATE OF BIRTH _____
3. IF YOU ARE CLAIMING FOR A DEPENDENT CHILD WHO IS 18 OR OLDER PLEASE INDICATE IF:
   - ☐ HANDICAPPED
   - ☐ STUDENT FOLLOWING A FULL TIME COURSE OF EDUCATION. IF STUDENT, NAME OF SCHOOL _____
     STUDENT NUMBER _____
4. IS ANY TREATMENT REQUIRED AS A RESULT OF AN ACCIDENT? ☐ YES ☐ NO
   IF YES, GIVE DETAILS _____
5. ARE YOU OR YOUR DEPENDENT'S ENTITLED TO DENTAL BENEFITS UNDER THIS OR ANY OTHER PLAN? ☐ YES ☐ NO
   IF YES, PROVIDE NAME OF FAMILY MEMBER, RELATIONSHIP TO YOU, NAME OF PLAN, CARRIER AND POLICY NUMBER (IF APPLICABLE):
   _____
6. ARE ANY OF YOUR DEPENDENTS ENTITLED TO BENEFITS, AS AN EMPLOYEE, UNDER THIS PLAN? ☐ YES ☐ NO
   IF YES, PROVIDE NAME OF FAMILY MEMBER AND RELATIONSHIP TO YOU:
   _____

PLEASE SEE REVERSE SIDE FOR CERTIFICATION AND CONSENT

CO-ORDINATION BETWEEN TWO PLANS

If you and your Spouse are both eligible for benefits under this Plan, the Administrator will automatically co-ordinate the benefits between your file and your Spouse's file, if you indicate 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 and your Dentist with the 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 authorize the release of the information contained in this claim form to the HyLife Foods/UFCW Local No. 832 Benefit Plan. I understand that the fees listed in this claim may not be covered or may exceed the Plan's benefits. I understand that I am financially responsible to the Attending Dentist/Denturist for the entire cost of the treatment.

I certify that the charges for the dental services and/or supplies which are identified on the reverse side of this form, or on the attached form provided by the Attending Dentist/Denturist 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 eligible 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 _____

If the dental expense has been incurred on behalf of your Spouse, 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 the dental expense has been incurred on behalf of a Dependent Child age 18 or over, 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 _____