HYLIFE FOODS/UFCW LOCAL NO. 832 BENEFIT PLAN

SMOKING CESSATION PRODUCTS CLAIM FORM

INSTRUCTIONS: Attach the receipts for all expenses. ***Note:*** Receipts are part of our records and will not be returned. Therefore please retain for Income Tax purposes, the itemization of expenses that will accompany our cheque.

Claims must be submitted to the Administrator no later than April 30 of the year following the year the expenses were incurred.

IMPORTANT: Please answer all questions and sign the reverse side of this form. This claim will be returned to you if it is incomplete or contains errors.

Please see reverse side for Certification and Consent

MEMBER'S STATEMENT

Member Name_____ S.I.N. _____

Mailing Address _____

Phone Number _____

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

DEPENDENT INFORMATION							**If Child age 18 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	Employed? Yes	No	How many hrs worked per week?

Are you, or your spouse or your dependent children eligible for reimbursement for Smoking Cessation products under any other plan? *(See "Steps To Follow - Co-ordination Between Two Plans" on the reverse of this form, when benefits are provided under more than one Plan)*

☐ No

☐ Yes (If "Yes" provide name of family member, relationship to you, name of other plan, Carrier and Policy Number):

_____

Is any member of your family (other than yourself) eligible for benefits under this Plan? ☐ Yes ☐ No

If "Yes" provide name of family member and relationship to you _____

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:
HYLIFE FOODS/UFCW LOCAL NO. 832 BENEFIT PLAN
3rd Floor, 880 Portage Avenue, Winnipeg, Manitoba R3G 0P1

CO-ORDINATION BETWEEN TWO PLANS

If you and your Spouse are both employees of HyLife Foods, and 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 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 and complete.

I certify that the charges for the vision care 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 who are under 18 years of age, as provided herein, as well as other personal information currently held or to be collected in the future, is required to: determine coverage and benefit entitlement; satisfy any reporting requirements of the provincial and federal governments; comply with civil and criminal law; determine future operating costs; 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 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 an expense has been incurred on behalf of your spouse, and is attached to this claim, please have your spouse sign the following.

I hereby consent to the use of my personal information in the same manner as described above.

Signature of Spouse _____ Date _____

If an expense has been incurred on behalf of a dependent child age 18 or over, and is attached to this claim, please have your child sign the following.

I hereby consent to the use of my personal information in the same manner as described above.

Signature of Dependent Child Age 18 or over _____ Date _____

Signature of Dependent Child Age 18 or over _____ Date _____