MANITOBA SAFEWAY/UFCW LOCAL 832 HEALTH & WELFARE PLAN 2
GAS BAR EMPLOYEES DENTAL BENEFITS CLAIM FORM

3RD FLOOR, 880 PORTAGE AVENUE, WINNIPEG, MANITOBA R3G 0P1
PHONE: 204-982-6024 FAX: 204-982-6080

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

PART 1 - DENTIST'S CERTIFICATION

1. IS ANY TREATMENT FOR ORTHODONTIC PURPOSES? ☐ YES ☐ NO

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

____
DENTIST/DENTURIST SIGNATURE

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

TOTAL FEE SUBMITTED

PART 2 - MEMBER'S STATEMENT

1. MEMBER'S NAME ______________________________
2. SOCIAL INSURANCE NUMBER ______________________________
3. MEMBER'S DATE OF BIRTH ______________________________
4. ARE YOU OR YOUR DEPENDANTS ENTITLED TO DENTAL BENEFITS UNDER ANY OTHER PLAN?
   ☐ YES ☐ NO

   IF YES, PROVIDE NAME OF FAMILY MEMBER, RELATIONSHIP TO YOU, NAME OF PLAN, CARRIER AND POLICY NUMBER (IF APPLICABLE):

   ____
5. ARE ANY OF YOUR DEPENDANTS EMPLOYEES OF CANADA SAFEWAY? ☐ YES ☐ NO

   IF YES, PROVIDE NAME OF FAMILY MEMBER AND RELATIONSHIP TO YOU:

   ____

PLEASE SEE REVERSE SIDE FOR CERTIFICATION AND CONSENT

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 on this claim form to the MANITOBA SAFEWAY/UFCW LOCAL 832 HEALTH & WELFARE PLAN 2. 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 my 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 my Dentist/Denturist, were incurred by me.

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 as provided herein, as well as other personal information currently held or to be collected in the future, is required to: communicate with you; 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. 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 have coverage under another plan, I hereby authorize the Board of Trustees and the Plan administrator to disclose personal information about me, 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