UFCW LOCAL 832 BUS DRIVERS' SICK LEAVE/HEALTH BENEFIT PLAN

HEALTH SPENDING ACCOUNT CLAIM FORM

INSTRUCTIONS: Attach the receipts for all expenses where possible, or where applicable a statement showing the portion already paid by another plan. *Note:* Receipts are part of our records and will not be returned. Therefore please keep for Income Tax purposes, the cheque stub that is attached to your cheque.

This Plan is second payor. If you have coverage under another plan, your claim must be submitted to that plan first and proof of what they paid must be attached to this claim.

Claims must be submitted to the Administrator by the January 31st immediately following the calendar year (January 1 to December 31) during which the expense was 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's Name ______________________________
(Last) (First)

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

Phone Number ____________________

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

Patient Name	Relationship to Member	Date of Birth			Does patient reside with you?		If Child age 18 or over: Full-Time Student?**		Student Number	Disabled?		Employed?	
		Year	Month	Day	Yes	No	Yes	No		Yes	No	Yes	No

**If a full-time student please provide name of educational institution ______________________

TOTAL AMOUNT CLAIMED $ __________

Are you, or your spouse or your dependent children eligible for benefits under any other 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) employed by FIRSTCANADA ULC? ☐ Yes ☐ No
If "Yes" provide name of family member and relationship to you ______________________

Are any of the expenses the result of an injury? ☐ Yes ☐ No
Is the injury due to a motor vehicle accident? ☐ No ☐ Yes (If Yes, has a claim been made to MPIC?) ☐ Yes ☐ No

Are any of the expenses the result of an illness/injury that is work related? ☐ Yes ☐ No
If Yes, has a claim been made to Workers' Compensation? ☐ Yes ☐ No

Any Member making a false claim may have his/her eligibility discontinued.

Please complete and return this form to:
UFCW LOCAL 832 BUS DRIVERS' SICK LEAVE/HEALTH BENEFIT PLAN
3rd Floor, 880 Portage Avenue, Winnipeg, Manitoba R3G 0P1
Phone: 982-6087 (in Winnipeg) or 1-877-982-6087 (outside Winnipeg)

Please Turn Over ➔➔➔

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 or other proofs of loss are attached, were incurred by me, or on behalf of one of my dependents.

I understand that my personal information and that of my eligible dependents 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 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.

______________________________ ______________________

Signature of Member Date

Also, 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 collection, recording, use, disclosure and, if applicable, destruction of my personal information in the same manner as described above.

______________________________ ______________________

Signature of Spouse Date

Also, 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 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

______________________________ ______________________

Signature of Dependent Child Age 18 or over Date