VANTAGE FOODS (MB)/UFCW BENEFIT PLAN

VISION CARE CLAIM FORM

This coverage is provided to employees only. Dependents are not eligible for this coverage.

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 complete the Member's Statement and sign the form.

MEMBER'S STATEMENT

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

Address _____
(Street No. & Street/Box No.) (City) (Province) (Postal Code)

Phone Number _____

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.

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 vision care services and/or supplies for which receipts are attached, 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 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. 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**

Please complete and return this form to:
Vantage Foods (MB) Inc./UFCW Benefit Plan
3rd Floor, 880 Portage Avenue, Winnipeg, Manitoba R3G 0P1
Phone: 982-6087 Fax: 982-6080