

## Group Benefits Extended Health Care Claim

To be completed by the plan member unless otherwise indicated. Original receipts must be attached for all expenses. (Please attach to the back of this form.) Please retain copies for your files as original receipts will not be returned.

### 1 Plan member information

You can obtain your plan no., account/division no. and your certificate no. from your I.D. card.

|   |                                    |                                |                                       |                          |
|---|------------------------------------|--------------------------------|---------------------------------------|--------------------------|
| Plan no.<br><b>961216</b>   | Acct./Div. no.                     | Certificate no. or SIN         | Plan sponsor<br><b>IBEW LOCAL 894</b> |                          |
| Plan member name (first, middle initial, last)  |                                    |                                | Birthdate (dd/mmm/yyyy)               |                          |
| Department/Branch name  |                                    | Delivery station/Branch number |                                       |                          |
| If home delivery is required, please provide your mailing address   |                                    | City or town                   | Province                              | Postal code              |
| Are these expenses eligible for coverage under any type of workers' compensation board? <input type="radio"/> Yes <input type="radio"/> No  |                                    |                                |                                       |                          |
| Are you, your spouse or dependants covered under any other plan for the expenses being claimed?<br><input type="radio"/> Yes <input type="radio"/> No   |                                    |                                |                                       |                          |
| If "Yes," please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier. If this is your first claim, or if information has changed, please provide the following: |                                    |                                |                                       |                          |
| Spouse's date of birth (dd/mmm/yyyy)  | Name of spouse's insurance company |                                | Spouse's plan no.                     | Spouse's certificate no. |

### 2 Claim information

Please complete all requested information and list expenses in date order. Use a separate line for each person and attach original receipts as well as the required written recommendation from the prescribing physician, including diagnosis, and a copy of the provincial plan statement of payment (if applicable). Incomplete forms or photocopied receipts cannot be processed for payment.

| Patient's name | Relationship to Employee | Date of birth (dd/mmm/yyyy) | If Dependant       |                 | Receipt date (dd/mmm/yyyy) | Description of expense* | Total charge |
|----------------|--------------------------|-----------------------------|--------------------|-----------------|----------------------------|-------------------------|--------------|
|                |                          |                             | Full-time student? | Full-time work? |                            |                         |              |
|                |                          |                             |                    |                 |                            |                         |              |
|                |                          |                             |                    |                 |                            |                         |              |
|                |                          |                             |                    |                 |                            |                         |              |
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|                |                          |                             |                    |                 |                            |                         |              |
|                |                          |                             |                    |                 |                            |                         |              |

\*Please identify the type of health expense (eg. vision, physiotherapy, etc.)

**Total amount of ALL receipts submitted \$**

**NOTE - ORIGINAL RECEIPTS must be attached for all expenses.**

**I certify that all goods or services being claimed have been received by me/my dependants.**

I certify that the information in this form is true and complete, to the best of my knowledge, and does not contain a claim for any expenses previously paid for by any plan.  
I authorize any person or organization who has information pertaining to this claim, including any health care provider, insurance company, any type of workers' compensation board, investigative agencies and my plan sponsor, to release and exchange such information requested by Manulife Financial and/or its claims service providers for the purpose of plan administration including processing and investigating this claim.  
I authorize Manulife Financial and its claims service providers to collect, to use and to exchange with the persons or organizations listed above any information needed for the purpose of plan administration including processing and investigating this claim.  
If this claim is made on behalf of my spouse and/or dependants, I am authorized to disclose information about them, for the purpose of plan administration including processing and investigating this claim.  
If my social insurance number is used as my certificate number, I authorize its use for the identification and administration of my group benefits.  
I agree that a photocopy or electronic version of this authorization shall be as valid as the original.  
At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a Group Life and Health Benefits file. Access to your information will be limited to:

- our employees and service representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

**Please sign here**

Signature of plan member

Date signed (dd/mmm/yyyy)

### 3 Mailing instructions

Please mail your completed claim form and receipts to the address below.

**IBEW LOCAL 894  
380 LAKE ROAD, UNIT 3  
BOWMANVILLE ON L1C 4P8**