

SECTION 1 - TO BE COMPLETED BY PLAN MEMBER

IBEW Local 894 Welfare Plan		961216	
Plan Sponsor		Plan contract number	Plan member certificate number/SIN
Plan Member – Last name		First name and initial	Date of birth (yyyy/mm/dd)
Address	No. Street	City	Province Postal code
1. Is this claim a result of traveling outside the country? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, from _____ to _____ (yyyy/mm/dd) (yyyy/mm/dd)			

Co-ordination of Benefits

2. Are any of these expenses related to a Workers' Compensation Claim? No Yes

3. Are benefits available from another group plan? No Yes
If yes, please provide the following information _____
Insurance carrier name Plan contract number

4. If other coverage was available and has recently terminated, please provide termination date _____
(yyyy/mm/dd)

The spouse who is covered by another medical plan must first submit his/her claim to his/her insurer. Once that has been completed, please provide Manulife Financial with a completed claim form and a copy of the settlement provided by the other carrier. Claims for children must first be submitted to the insurer of the parent whose birthday occurs first in the calendar year.

Claim Information
Please complete all requested information and list expenses in date order. Use a separate line for each person and attach original receipts. Incomplete forms or photocopied receipts cannot be processed for payment.

Patient name	Relationship to plan member	Date of birth (yyyy/mm/dd)	If dependant		Receipt date (yyyy/mm/dd)	Description of expense *	Total charge
			Full-time student?	Full-time work?			

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

SECTION 2 - DECLARATION & AUTHORIZATION

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Plan Member's Signature: _____ **Date:** _____

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers 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, where appropriate, to have any inaccurate information corrected.

Mail your completed claim form and original receipts to: IBEW Local 894
380 LAKE RD UNIT 3
BOWMANVILLE ON L1C 4P8

All dates in yyyy/mm/dd format

Plan contract number / Division / Class	Employment date	Insured date	<input type="checkbox"/> Single coverage	Dependant insured date	Termination date
			<input type="checkbox"/> Family coverage		
Signature of Plan Administrator			(yyyy/mm/dd)		