

**THE MILLWRIGHT BENEFIT PLAN  
HEALTH TRUST FUND  
GROUP HEALTH CLAIM FORM**

<b>MEMBER – Complete this section (please print)</b>			
Member's Name:	Certificate Number		Date of Birth
			Day    Month    Year
Member's Address	City	Province	Postal Code

1. If you are making a claim for a Dependent, please provide the following information:

Name	Date of Birth Day /Mth /Year	Relationship spouse/child	Is Dependent working? (yes or no)	Is Dependent in school? (yes or no)	If working, provide name of employer If in school, provide name of institution

2. Are group health benefits payable from any other source?     yes     no    Name Source: \_\_\_\_\_

3. Are any expenses due to sickness or injury arising out of any employment of the employee or dependent?     yes     no

If yes, provide date and details \_\_\_\_\_

Is claim being made for Workers Compensation Board (WCB) benefits?     yes     no

4. Name and address of prescribing physician(s) \_\_\_\_\_

**ORIGINAL RECEIPTS MUST BE ATTACHED TO THIS FORM**

5. Total amount of this claim: \$ \_\_\_\_\_

I hereby certify that the above statements are true, accurate and complete to the best of my knowledge and belief. And that the attachments to this form are receipts in connection with the medical treatment of the above named individuals. I understand that the Plan Administrator will use the information provided by me on this claim form strictly for the purpose of processing my claim. I hereby authorize the use of my Social Insurance Number for tax reporting and the administration of my benefits. I hereby authorize the Plan Administrator to evaluate or investigate my claims and release my personal information (including health information) to qualified third parties solely for the purpose of conducting such evaluations or investigations, and only to the extent required for such purposes. I hereby authorize my union, physician or other health professionals, any medical facility, any insurance company or government body, and any other person or institutions to release relevant information to the Plan Administrator solely for the purpose of processing this claim. A photocopy of this release shall be as valid as the original.

Member's Signature	Date	Phone Number
--------------------	------	--------------

<b>Member – submit completed claim form and original receipts to:</b>  Manion, Wilkins & Associates Ltd 626 - 21 Four Seasons Place, Etobicoke ON M9B 0A6 (416) 234-3511 Toll Free: 1-800-263-5621	<b>For Plan Administrator Use Only – do not write in this area</b>  Policy Number: <b>918163</b>	
---	--	--