**CANADIAN ELEVATOR INDUSTRY WELFARE PLAN**

**CLAIM FORM**

**FOR EXTENDED HEALTH CARE PLAN**
**PRESCRIPTION DRUG PLAN**
**VISION PLAN**

| PLAN NUMBER | CERTIFICATE NUMBER | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 3000 | | | | | | | | | |

**NOTE:**
- **ORIGINAL RECEIPTS (NOT PHOTOCOPIES) MUST ACCOMPANY THIS CLAIM FORM**
- **EACH RECEIPT MUST INCLUDE THE PATIENT'S NAME**
- **PRESCRIPTION DRUG RECEIPTS MUST SHOW NAME, STRENGTH AND QUANTITY OF DRUG PLUS PRESCRIPTION NUMBER AND DRUG IDENTIFICATION NUMBER**

PLEASE ANSWER THESE QUESTIONS

IS THIS A WORKER'S COMPENSATION CASE (WCB)?
( ) YES ( ) NO
IS YOUR CLAIM A RESULT OF AN ACCIDENT?
( ) YES ( ) NO
DO YOU (OR YOUR DEPENDENT) HAVE OTHER INSURANCE TO COVER THESE BENEFITS?
( ) YES ( ) NO

IF YES, GIVE:

INSURANCE COMPANY NAME GROUP/POLICY NO. CERTIFICATE NO.

| | |
|---|---|
| MEMBER'S NAME | |
| STREET | APT. # |
| CITY & PROV. | |
| POSTAL CODE | |

MEMBER'S DATE OF BIRTH DAY MONTH YEAR

TELEPHONE NO. BUSINESS

NAME OF PRESENT EMPLOYER _____

I AM CURRENTLY RECEIVING BENEFITS UNDER U.I.C. ❑ W.C.B. ❑

**PLEASE SUBMIT COMPLETED CLAIM FORM TO:**

Manion, Wilkins & Associates Ltd
626 - 21 Four Seasons Place, Etobicoke ON
M9B 0A6
416-234-3511
1-800-263-5621 (Toll Free)

**NOTE: PAYMENT IS MADE ONLY TO PLAN MEMBER**

| FIRST NAME OF DEPENDENT | DEPENDENT'S DATE OF BIRTH | RELATIONSHIP (SPOUSE/CHILD) | IS CHILD FINANCIALLY DEPENDENT? (YES OR NO) | IS DEPENDENT IN SCHOOL? (YES OR NO) | IF IN SCHOOL, PROVIDE NAME OF INSTITUTION |
|---|---|---|---|---|---|
| | / / DAY MO. YEAR | | | | |
| | / / DAY MO. YEAR | | | | |
| | / / DAY MO. YEAR | | | | |
| | / / DAY MO. YEAR | | | | |

| ALL MEMBER EXPENSES SHOULD BE LISTED HERE. ATTACH RECEIPTS. | | | ALL DEPENDENT'S EXPENSES SHOULD BE LISTED HERE. ATTACH RECEIPTS. | | | |
|---|---|---|---|---|---|---|
| RECEIPT DATE DAY MO. YEAR | PRESCRIPTION NUMBER OR DESCRIPTION OF ITEM | CHARGE | RECEIPT DATE DAY MO. YEAR | DEPENDENT'S NAME | PRESCRIPTION NUMBER OR DESCRIPTION OF ITEM | CHARGE |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| TOTAL | | | TOTAL | | | |

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE PLAN ADMINISTRATOR WILL USE THE INFORMATION PROVIDED BY ME ON THIS CLAIM FORM STRICTLY TO PROCESS MY CLAIM. 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.

| SIGNATURE OF MEMBER | DATE |
|---|---|
| | |

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL