THE IRONWORKERS LOCAL 764
BENEFIT TRUST FUND
GROUP HEALTH CLAIM FORM

MEMBER – Complete this section *(please print)*			
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

Member – submit completed claim form and original receipts to:	**For Plan Administrator Use Only – do not write in this area**
Manion, Wilkins & Associates Ltd 626 - 21 Four Seasons Place, Etobicoke ON M9B 0A6 1-800-263-5621 (Toll Free)	Policy Number: 00380000