SHEET METAL WORKERS L.U.296 HEALTH & WELFARE TRUST FUND
c/o THE PLAN ADMINISTRATOR
1355 11th Avenue,, REGINA SK S4P 0G8
Phone: 306-757-5482

PRESCRIPTION DRUG/VISION/OTHER MEDICAL CHARGES CLAIM FORM

Note: Attach all original bills and receipts for which a claim is being made.
Incomplete information will delay processing of the claim.

INSURED MEMBER to complete this section. Please print.
Group Plan Name: Sheet Metal Workers L.U. 296
Group Plan Number: 44791

Name: _____
Address: _____
_____ **PC**_____

MEMBERS SIN # _____ _____ _____
Phone # _____
___ Please check if address has changed in the past year

Are any benefits or services under any other Group Insurance Plan?
Yes ____ No _____
If Yes, please indicate who is insured under the other plan.
Self _____ Spouse _____
If spouse, please provide spouse's date of birth. D M Y

Effective Date of coverage D M Y

Name of Insurer _____Policy No. _____
**Note: For coordination of benefits, Dependent children must be claimed under the Plan of the parent with the earlier day and month of birth, in the calendar year.

ACCIDENT INFORMATION:
Are any of the expenses being claimed due to an accident? Yes _____ No _____
If yes, did the accident take place at work? Yes ____ No ___
Please provide a letter: explaining details of the accident and indicating if another party is liable. Date of accident : D D M M Y Y

Patient(s) Name(s):	Relationship to member:	Dates of Birth /Gender	If dependent age 21 or over, indicate
1.		/	Student ____ Handicapped _____,
2.		/	Student ____ Handicapped _____,
3.		/	Student ____ Handicapped _____,
4.		/	Student ____ Handicapped _____,

PRESCRIPTION DRUG CHARGES / OTHER MEDICAL CHARGES
Original receipts showing prescription number, name of drug, date of bill and amount must be attached.

Receipt Date	Description	Charge
	Total	

VISION CARE CHARGES
Original itemized receipts must be attached.
Patient _____
Date of Service _____
Charges for:

Examination fee	$
Lenses/Frames	$
Total charges	$

Is this a new prescription? Yes ___ No ____
Lenses Single___, Bifocal __,Contact Lenses___, Other__

HEALTHCARE SPENDING ACCOUNT
The plan has recently revised its procedures whereby any remaining Health or Dental benefit expenses not covered by the basic Plan (i.e. deductibles, claims that have exceeded an allowable maximum, etc.) are now automatically applied to the extent of your Healthcare Spending Account, if any, unless you indicate otherwise below. The exception would be in instances of co-ordination of benefits with your Spouse's plan. ☐ Do NOT apply remaining claims expenses automatically to my H.S.A.

MEMBER DECLARATION: I AUTHORIZE… **A copy of this authorization shall be as valid as the original.**

1. my personal physician and any health care professionals, public/private health or social services organization, insurer, re-insurer, employer, or other public/private organization or person that has record or knowledge of me or my health, or of any of my minor children being insured or of their health, to give any such personal information to the Plan Administrator/Insurer, its re-insurers, or any consumer reporting agency acting on its behalf, for assessment of claims, and benefit administration.
2. the Plan Administrator or the insurer to obtain from exchange with any of these organizations or persons any such personal information for the same purposes,
3. the use of my Social Insurance Number (SIN) for claim identification (members only) and, as required by law, for Income Tax Reporting.

Date _____ **Insured Member's Signature** _____

FOR PLAN ADMINISTRAOR USE ONLY: Date:_____

Effective date of Member's Coverage:_____ Authorized Signature:_____
Day Month Year

All information recorded on this form is confidential

2012-08-20 Form