

**THE NEWFOUNDLAND AND LABRADOR REGIONAL COUNCIL OF CARPENTERS,  
MILLWRIGHTS AND ALLIED WORKERS WELFARE TRUST FUND  
HEALTH CLAIM FORM**

| <b>MEMBER – Complete this section (please print)</b> |                    |          |                                       |
|--|--------------------|----------|---------------------------------------|
| Member's Name:                                       | Certificate Number |          | Date of Birth<br>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<br>Day /Mth /Year | Relationship<br>spouse/child | Is<br>Dependent<br>working?<br>(yes or no) | Is<br>Dependent<br>in school?<br>(yes or no) | If working, provide name of<br>employer<br>If in school, provide name of<br>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 Member 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. 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.

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

|   |  |
|---|--|
| <p><b>MEMBER – submit completed claim form and original receipts to:</b></p> <p>Manion, Wilkins &amp; Associates Ltd<br/>626 - 21 Four Seasons Place,<br/>Etobicoke ON<br/>M9B 0A6<br/>(416) 234-3511<br/>Toll Free: 1-800-263-5621</p> | <p><b>For Plan Administrator Use Only – do not write in this area</b></p> <p>Policy Number:<br/>901340</p> |
|---|--|