MILLWORKERS HEALTH & WELFARE PLAN (UNIFOR)

45 McINTOSH DRIVE, MARKHAM, ON L3R 8C7
Phone: 1-800-263-3564 Fax: 905-946-2535
Email: questions@millworkersuniforbenefits.org

EXTENDED HEALTH BENEFITS CLAIM

Policy No.	I.D./Certificate Number	
Member Last Name	First Name	
Member Address	City	Postal Code
Name of Employer or Union Affiliation		

Complete form, attach receipts and forward to:

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PharmaCare Registration No.

LIST EXPENSES BELOW, GROUPED BY INSURED PERSON, IN DATE ORDER

Please include all applicable receipts. In case of dual coverage, send Statement of Payment from primary insurer along with photocopies of original receipts.

***PLEASE NOTE: Receipts will not be returned. Please retain copy if required.**

Name (Employee or Insured Dependent)	Relationship to Employee	Birth Date yr/mo/day	Date of Purchase yr/mo/day	Drug/Service Provided	Prescription DIN	Amount Charged
						$

Additional space on reverse

NOTE: Birthdate for all dependents (spouse & children) must be given.
If dependent is age 21 or older, indicate school they are attending.

School: _____

☐ Full Time ☐ Part Time

Are any benefits or services provided under any other insurance or supplementary health plan? ☐ ***YES*** ☐ ***NO***

If "Yes", indicate:

Policy No.: _____ **Name of insuring agency:** _____

Name of Insured: _____ **I.D./Certificate Number:** _____ **Date of Birth** (y/m/d): _____

Are any of the above expenses the result of a motor vehicle accident/Workers Compensation claim? ☐ ***YES*** ☐ ***NO***

If "Yes", please specify and explain:

Privacy Statement: I authorize the Millworkers Health & Welfare and Pension Plans (together called "the Plans"), their administrator Employee Benefit Plan Services Limited, and providers working with the Plans or administrator to collect, maintain, use and disclose my personal information that is necessary for the administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plans may collect, maintain, use and disclose my personal information with relevant persons or organizations(employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal counsel, other plans or unions, pharmacies, regulators, re-insurers) in order to manage the Plans and entitlement to the benefits of the Plans, and may include information such as financial, health or benefits related information. Questions related to the Privacy Statement should be directed to the Privacy Officer

✱Member Signature: _____ Date: _____

Name (Employee or Insured Dependent)	Relationship to Employee	Birth Date yr/mo/day	Date of Purchase yr/mo/day	Drug/Service Provided	Prescription DIN	Amount Charged
						$

PLEASE SUBMIT COMPLETED FORM TO THE PLAN ADMINISTRATOR:

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