UA LOCAL 787 HEALTH PLAN

HEALTH CARE CLAIM FORM

INSTRUCTIONS: Bills or receipts must be attached for each expense and fully itemized in the space provided below.

IMPORTANT:
a) Part 1 must be completed and signed by the Member before your claim can be processed.
b) If any of the requested information is missing or incomplete, this claim may be returned.
c) Send claim to: EMPLOYEE BENEFIT PLAN SERVICES LTD.
45 McINTOSH DRIVE, MARKHAM, ONTARIO L3R 8C7 or **SUBMIT ONLINE at http://www.ualocal787.org.**
TELEPHONE TORONTO AREA: 905-946-2220 • CANADA TOLL FREE: 1-866-946-2220 • FAX 905-946-2535

PART 1 – MEMBER'S STATEMENT AND AUTHORIZATION

MEMBER'S NAME		DATE OF BIRTH
STREET ADDRESS		APT/UNIT #
CITY/PROVINCE	POSTAL CODE	Is this a new address since last claim? Yes ☐ No ☐
MOST RECENT EMPLOYER		UNION IDENTIFICATION NUMBER
1. Are you or any other member of your family entitled to visioncare or medical benefits under any other plan? Yes ☐ No ☐		
If yes, name of family member insured		Relationship to Member
Name of other Insurance Company and policy number		
2. If yes to question 1 or 2 above, and the patient is a dependent child, give: Employee's birthday (Day/Month) AND Spouse's birthday (Day/Month) _		

AUTHORIZATION AND SIGNATURE:
I certify that, if this claim is being made on behalf of my Spouse and/or Dependents, I am authorized to disclose information about them, for the purpose of assessing and paying a benefit, if any. I certify that the information given is true, correct and complete to the best of my knowledge. I understand that this information will be protected pursuant to the relevant privacy legislation. I authorize the Administrator, its agents and service providers to use and exchange information needed for administering and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim, including Health Professionals, Institutions, Investigative Agencies, Insurers, Re-Insurers and Regulators. I understand that information pertaining to this claim may be reviewed in the event that this Plan is audited.

DATE **MEMBER'S SIGNATURE** _

PART 2 – VISIONCARE STATEMENT

NAME OF PATIENT	
DATE OF BIRTH	RELATIONSHIP TO MEMBER
If patient is a Dependent, does the patient reside with you? Yes ☐ No ☐	
If Child is 21 years or older: Full-time Student? Yes ☐ No ☐ Employed? Yes ☐ No ☐ If yes, how many hours work per week? _____	
1. Is this your first pair of glasses/contact lenses? Yes ☐ No ☐ If no, please advise if the prescription has been change. Yes ☐ No ☐	
2. If no to question 1, provide the approximate date the last pair was obtained.	

PART 3 – TO BE COMPLETED BY MEMBER (please attach receipts)

1. Date of Service _____	4. Other $ _____
2. Charge for Glasses $ _____	5. Give reasons & specific item for other charges in question 4 (ie: hardening, tinting, varigray, oversize lenses, etc.)
3. Charge for Contact Lenses $ _____	

PART 4 – MEDICAL EXPENSE STATEMENT (please itemize expense by patient)

NAME OF PATIENT	
DATE OF BIRTH	RELATIONSHIP TO MEMBER
If patient is a Dependent, does the patient reside with you? Yes ☐ No ☐	
If Child 21 years or older: Full-time Student? Yes ☐ No ☐ Employed? Yes ☐ No ☐ If yes, how many hours worked per week? _____	

DRUG CHARGES

PRESCRIPTION (Rx) #	DATE OF PURCHASE	NAME OF PRESCRIBED DRUG OR D.I.N REQUIRED	CHARGE

OTHER EXPENSES

PROVIDER OF SERVICE	DATE OF SERVICE	TYPE OF SERVICE	CHARGE

PART 4 – MEDICAL EXPENSE STATEMENT (please itemize expense by patient)

NAME OF PATIENT	
DATE OF BIRTH	RELATIONSHIP TO MEMBER
If patient is a Dependent, does the patient reside with you? Yes ☐ No ☐	
If Child 21 years or older: Full-time Student? Yes ☐ No ☐ Employed? Yes ☐ No ☐ If yes, how many hours worked per week? _____	

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PRESCRIPTION (Rx) #	DATE OF PURCHASE	NAME OF PRESCRIBED DRUG OR D.I.N REQUIRED	CHARGE

OTHER EXPENSES

PROVIDER OF SERVICE	DATE OF SERVICE	TYPE OF SERVICE	CHARGE

Member's Authorization in Part 1 must be completed