U.A. LOCAL 254 HEALTH & WELFARE TRUST FUND

MEDICAL CLAIM FORM

ADMINISTRATOR: GLOBAL BENEFITS
MANULIFE FINANCIAL
Policy Nº. 4513

INSTRUCTIONS TO EMPLOYEE

1. Complete the Employee's Statement (below) and include your date of birth and Social Insurance Number.
2. All correspondence, claim forms etc. should be mailed to:

   Global Benefits
   545 Wilson Ave., Toronto, ON M3H 1V2
   Phone: (416) 635-6000 Fax: (416) 635-6464
3. All receipts should be attached to this form.

DATE OF BIRTH

D	M	Y

SOCIAL INSURANCE NUMBER

EMPLOYEE'S STATEMENT

1. Name — Address (Give Number, Street, City & Prov.) — Home Phone No.

2. Single or Married ☐ ☐ — Male or Female ☐ ☐ — Occupation — Postal Code (at home)

3. IF DEPENDENT CLAIM, please complete.
   Name of Dependent — Male or Female ☐ ☐ — Relationship — Date of Birth / / (Day Month Year) — Single or Married ☐ ☐

   Have you (or your dependent) any other coverage which would pay a benefit for this claim? ☐ Yes ☐ No

   If "Yes", name of Employer and Insurance Co.

   If "Yes", please indicate spouse's date of birth.

   If child, indicate ☐ Student ☐ Handicapped

4. Vision Care Expenses - Attach all receipts and provide the following breakdown:

Frames		$______ .
Lenses	Single Vision	$______ .
	Multiple Focal	$______ .
Contacts		$______ .

Have you any other coverage which would pay a benefit for this claim? **Yes** ☐ **No** ☐

I authorize Global Benefits to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Global Benefits will be kept confidential and, where necessary, Global Benefits will be exchanging my personal information. I authorize the following persons to exchange with Global Benefits or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, or plan administrator, government agency, auditing or independent investigative organization, and financial institution. I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Date ___ / ___ / ___ (Day Month Year) Signature of Member ______________________ Telephone Number ( ) ______________

FOR ADMINISTRATOR'S USE ONLY