NO FRILLS/UFCW LOCAL 1000A BENEFIT TRUST FUND

NO FRILLS/UFCW LOCAL 1000A BENEFIT PLAN

SUPPLEMENTARY HEALTH
STATEMENT OF EXPENSES

INSTRUCTIONS: Attach the bills and receipts for all expenses and itemize them by providing all the information requested. Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors.

Please Print

MEMBER'S STATEMENT

PLAN NUMBER	DIVISION NO.	MEMBER NAME
850	**N/A**	

SOCIAL INSURANCE NUMBER | DATE OF BIRTH

ADDRESS: NUMBER AND STREET | TOWN | PROVINCE | POSTAL CODE | PHONE # HOME: | WORK:

COORDINATION OF BENEFITS

Are you or any other member of your family entitled to benefits under any other plan? Yes _ No _

If "Yes", name the family member insured: Relationship to employee:

Name of other insurance company: Policy Number:

SEND THIS CLAIM TO:

PBAS
61 International Blvd.
Suite 110
Toronto, Ontario
M9W 6K4

416-674-3350
1-800-461-4361

Is treatment required as the result of an accident? Yes _ No _ If "Yes", give date, location and explain how the accident happened:

Is a claim being made for Workers' Compensation Benefits through WSIB? Yes _ No _

CLAIM DETAILS

Patient Name	DRUG EXPENSES		OTHER EXPENSES		
	Number Of Receipts	Total Charge	Type Of Expense	Nature Of Illness	Total Charge

(If additional space is needed, attach separate page)

Please see reverse side for Certification And Consent.

Revised September 2022

CERTIFICATION AND CONSENT

I understand that it is an offense to make a false or misleading statement regarding the personal and claims information provided herein and declare that the information is true, correct and complete.

I certify that the charges for the medical services and/or supplies which are identified on the reverse side of this form, and for which receipts are attached, were incurred by me, or on the account of one of my eligible dependants, on the recommendation and approval of an attending physician, and were required in connection with the treatment of an injury or illness suffered by me.

I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in strictest confidence and will only be used for the specified purpose.

I understand that my personal information and that of my eligible dependants, as provided herein, as well as other personal information currently held or to be collected in the future, is required to: communicate with me; determine coverage and benefit entitlements; process claims for expenses incurred; satisfy any reporting requirements of the provincial and federal governments; comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan.

I hereby authorize the Board Of Trustees and the service agencies they employ to collect, record, use, disclose and, if applicable, destroy my personal information and that of my dependants who are under 18 years of age. I understand that all personal information will be kept confidential and secure, and that it will only be used for the purposes identified herein. Also, I understand that I may review the information, referenced herein, for myself or my dependants, who are under 18 years of age, to ensure that it is up-to-date, and that I may withhold or revoke my consent for its use, at any time. However, I realize that if I withhold or revoke my consent for its use, thereby limiting or restricting the ability to determine coverage and benefit entitlements, my participation in the Plan may be impaired or cancelled.

If I, or my dependants under 18 years of age, have coverage under another plan, I hereby authorize the Trustees to disclose personal information about me and my dependants in order to determine eligibility for coverage in the settlement of claims.

A photostatic copy of this authorization will be as valid as the original.

_____ _____

Signature of Plan Member Date

If an expense has been incurred by an eligible dependant child age 18 or older, and is attached to this claim, please have your child sign the following.

I hereby consent to the collection, recording, use, disclosure and, if applicable, destruction of my personal information in the same manner as described above.

_____ _____

Signature of Dependant
Child Age 18 or Over

Date

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