UFCW/MAPLE LEAF FOODS INC. BENEFIT PLAN ◆ MAJOR MEDICAL CLAIM FORM

INSTRUCTIONS:

- Answer **ALL** questions. This claim will be returned to you if it is incomplete.
- Attach receipts for all expenses. *Note:* Receipts will not be returned; please keep copies for your records.
- For payments assigned to Providers, attach itemized statements for each service.
- **Prescription Drugs: Manitoba Members Only -** Attach all original Pharmacare receipts. Each year, remember to attach to your first claim after April 1st, a copy of your new Pharmacare Deductible Letter.

CLAIMS MUST BE SUBMITTED NO LATER THAN 60 DAYS AFTER THE DATE THE EXPENSE WAS INCURRED

MEMBER'S STATEMENT

Member's Name _____ Phone Number _____
(Last) (First)

Address _____
(Number and Street) (City) (Province) (Postal Code)

S.I.N. or CERTIFICATE NUMBER _____

I hereby certify that this claim is being made for expenses incurred on behalf of:

						If Child age 22 or over			
Patient Name	Relationship to Member	Date of Birth Year	Month	Day	Does patient reside with you? Yes / No	Full-Time Student? ** Yes / No	Student Number	Handi-capped? Yes / No	Employed? If Yes, how many hours per week? Yes / No

****IF A FULL-TIME STUDENT PLEASE PROVIDE NAME OF EDUCATIONAL INSTITUTION** _____

ARE YOU, OR YOUR DEPENDANTS, ELIGIBLE FOR MEDICAL BENEFITS UNDER ANOTHER PLAN? (See reverse for instructions)
☐ No ☐ Yes. If Yes, provide name of family member, relationship to you, name of other plan, Insurance Company and Policy Number _____

ARE ANY OF YOUR DEPENDANTS EMPLOYED BY MAPLE LEAF FOODS?
☐ No ☐ Yes. If Yes, provide name of family member and their S.I.N. _____

ARE ANY OF THE EXPENSES THE RESULT OF AN INJURY?
☐ No ☐ Yes. If Yes, how did the injury happen? _____

_____

- If the injury is due to a motor vehicle accident has a claim been made to MPI or your private auto insurance?

☐ No ☐ Yes

ARE ANY OF THE EXPENSES DUE TO A MEDICAL CONDITION THAT IS WORK RELATED? ☐ No ☐ Yes

- If Yes, has a claim been made to Workers' Compensation/WSIB? ☐ No ☐ Yes

PAYMENT OPTIONS

If payment is being made to you, HAS YOUR BANKING INFORMATION CHANGED? If it has, you will need to complete and attach a Notification Of Change Form (available on the Union website, from your employer or the Administrator).

Is payment to be made directly to the Provider of the treatment?
☐ No ☐ Yes. If Yes, ask your Provider to complete the following:

Provider Number _____ Name _____

Address _____

I understand that all or a portion of the charges claimed may not be eligible under the Benefit Plan and that I am financially responsible to the Provider named above for the full cost of the treatment. I certify that I am aware of, and have read, the Certification And Consent on the reverse side of the claim form.

Signature of Member _____ Date _____

ANY MEMBER MAKING A FALSE CLAIM MAY HAVE HIS/HER ELIGIBILITY DISCONTINUED AND/OR THE TRUSTEES MAY COMMENCE SUCH LEGAL ACTION AS THEY DEEM NECESSARY AND APPROPRIATE IN THE CIRCUMSTANCES.

CO-ORDINATION BETWEEN TWO PLANS

If you and your Spouse are both employees of Maple Leaf Foods, and are both eligible for benefits under this Plan, the Administrator will automatically co-ordinate the benefits between your file and your Spouse's file if you indicate this on the reverse side of this form.

If you and your Spouse are members of 2 different plans, which provide the same benefits for which you are claiming, the steps are as follows.

Step 1 - submit a claim for your expenses to this Plan for reimbursement. The payment details will be sent to you with your payment. Submit this information to your Spouse's plan for reimbursement of any unpaid balance.

Step 2 - your Spouse must submit a claim for his/her expenses to his/her plan for reimbursement. When he/she receives details of the payment made, submit a copy of this information to this Plan for reimbursement of any unpaid balance.

Step 3 - claims for your children should ***first*** be submitted to the plan of the parent whose birth month is the earlier in the year, ***then*** to the other plan.

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 to the best of my knowledge and belief.

I certify that the charges for the 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 behalf of one of my dependants.

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 you; determine coverage and benefit entitlement; 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 the personal information noted on the other side of this form. 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 this information 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 entitlement, my participation in the Plan may be impaired or cancelled.

If I, or my dependants, have coverage under another plan, I hereby authorize the Board of Trustees and the Plan administrator to disclose personal information about me, and such dependants, in order to determine coverage and benefit entitlement.

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

Please complete and mail this form to:
UFCW/MAPLE LEAF FOODS INC. BENEFIT PLAN
3rd Floor, 880 Portage Avenue, Winnipeg, Manitoba R3G 0P1
Phone: 204-982-4170 (in Winnipeg) 1-877-982-4170 (outside Winnipeg)

OR

Scan the completed form and all receipts and send by e-mail to:
mapleleaf@pbas.ca