LABORERS' HEALTH & WELFARE TRUST FUND OF WESTERN CANADA

HEALTH CARE EXPENSE OPTION CLAIM FORM

Use this form to submit claims to be paid from your Health Care Expense Option. Refer to your Plan Booklet for a list of expenses which qualify. ***Do not use this form for claims covered under your group benefits plan.***

MEMBER INFORMATION

LOCAL UNION			
LAST NAME	**FIRST NAME**		**CERTIFICATE NUMBER**
ADDRESS		**DATE OF BIRTH** (MM/DD/YY)	**GENDER** ☐ Male ☐ Female
CITY	**PROVINCE**	**POSTAL CODE**	**PHONE NUMBER**

If claim is on behalf of an eligible dependent, please answer the following

DEPENDENT NAME	**STATUS** ☐ Spouse ☐ Child	**GENDER** ☐ Male ☐ Female	**DATE OF BIRTH** MM/DD/YY)
If the claim is for a dependent child 18 years of age or older, please indicate: School Name _____	**STUDENT STATUS** ☐ Full-time ☐ Part-time		**EXPECTED DATE OF GRADUATION** (MM/DD/YY)

List and attach all paid receipts or invoices for this claimant

ITEM SUBMITTED	NAME OF SUPPLIER	DATE OF PAID RECEIPT	AMOUNT CHARGED

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Ellement Consulting Group to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize the release of the information contained in this claim form to the Insurer/Plan Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the claim and to administer the group benefit plan, I certify that the information given is true, correct and complete to the best of my knowledge and that each of the above expenses are for medical treatment that I and/or my dependents received. I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the supplier for the entire amount.

SIGNATURE OF MEMBER **DATE** (MM/DD/YY)

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Pensions | Benefits | Investments

Please return to:
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