**Carpenters' And Millwrights' Health & Welfare**
**Benefit Trust Fund Of Saskatchewan**

# Supplementary Health Claim Form

**Instructions:** Attach the original receipts for all expenses. Receipts will not be returned, as a copy of the Explanation of Benefits is sent to you and copies of receipts are sufficient for income tax purposes or coordination of benefits with other group plans.

For ***Out of Country*** claims please contact Mondial Assistance at 1 (800) 265-9977 (Canada/U.S) or www.manulife.ca/group benefits/travel for additional information and for participating countries.

***Your claim will be returned to you if the claim form is incomplete.***

## 1. Member Information

| Plan Sponsor / Employer Name | | | Group Number |
|---|---|---|---|
| | | | |

| Last Name | First Name | Certificate Number/SIN |
|---|---|---|
| | | |

| Address | Gender | Language | Date of Birth (MM/DD/YY) |
|---|---|---|---|
| | Male<br>Female | English<br>French | |

| City | Province | Postal Code | Phone Number |
|---|---|---|---|
| | | | |

## 2. Patient Information

Does the patient have any other coverage which would pay a benefit for this claim? Yes No

If yes, please indicate the date of birth of the insured: ____________ (MM/DD/YY) ______________

If yes, attach photocopies of vision receipts and the co-insurance statement.

Is the treatment required as the result of an accident? Yes No

If yes, indicate the accident date, location and details on how the accident occurred. ______________________________

______________________________________________________________________

Is the treatment required as the result of a work related injury? Yes No

If yes, is a claim being made for Worker's Compensation benefits? Yes No

### Claim Details

| Patient Name (Last, First) | Relationship to Member | Date of birth (MM/DD/YY) | Type of Service | Date of Service (MM/DD/YY) | Total Charges |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Do you want any unpaid portion of your claim processed through your Health Spending Account? Yes No

### To Assign Payment to Supplier:

I hereby assign my benefits payable from this claim to ________________________________ and authorize payment directly to the supplier.
(Name of Supplier)

________________________________________

**Member Signature**

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Manulife Financial to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize 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:**
Ellement Consulting Group
10154 108 Street NW Edmonton AB, T5J 1L3
Toll free: 1-800-770-2998

Phone (780) 452-5161 Fax (780) 452-5388

# PHYSICIAN'S RECOMMENDATION
## (FOR MAJOR MEDICAL SUPPLIES)

1. Patient's Name ______________________________
2. Recommended medical item(s) – describe in detail including specifications when available ______________________________
3. Indicate activities requiring this item ______________________________
4. Diagnosis of medical condition with specific reason for recommendation of medical item(s) ______________________________

   ______________________________
5. Condition of patient: Acute Chronic Palliative
6. 
   a. Date patient first consulted you for this condition (month/day/year) ______________________________
   b. Are you actively treating this patient for this condition Yes No If no, please provide comments

   ______________________________

   ______________________________
7. To the best of your knowledge, what is the duration for use of the recommended item(s) ______________________________
8. For hospital beds only, please indicate the hours or percentage of time in bed ______________________________
9. For replacement of a prosthesis or other equipment, please provide:
   a. Date of prior replacement (MM/DD/YY) ______________________________
   b. Reason for replacement ______________________________
10. Is the device(s) and/or medical equipment required:
    a. As a result of a work related injury? Yes No
    b. As a result of a motor vehicle accident? Yes No
    c. For sports purpose only? Yes No
11. Has an application been made for government funding? Yes No If no, please give reason

    ______________________________

______________________________ ______________________________
Physician's Name Physician's Signature General Practitioner
Specialist

______________________________ ______________________________
Date (MM/DD/YY) Phone Number

***THE PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND ANY CHARGES MADE FOR ITS COMPLETION.***

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SIGNATURE OF MEMBER DATE (MM/DD/YY)

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