Manulife Financial

Major Medical
Statement of Claim

CLAIMS PROCESSED BY EMPLOYEE BENEFIT PLAN SERVICES - see below for submission instruction

GROUP POLICY No. 901902 LABOURER'S LOCAL 493 BENEFIT TRUST FUND

1. Plan member's name _____ Date of birth ____/____/____ (Day / Month / Year)

2. Address _____ (Street) SIN | | | | | | | | | |

_____ (City) (Province) Postal Code _____

3. Is this your first claim with Manulife Financial? ☐ Yes ☐ No

4. If you are making a claim for a Dependant, please provide the following information:

First name of dependant	Dependant's date of birth (Day / Mo. / Yr.)	Relationship (Spouse/Child)	Is Dependant working? (Yes or No)	Is Dependant in school? (Yes or No)	If working, provide name of employer If in school, provide name of institution
	/ /				
	/ /				
	/ /				
	/ /				

5. Are group health benefits payable from any other source? ☐ Yes ☐ No Name source _____

6. Name and address of prescribing physician(s). _____

7. **All Plan Member** expenses should be listed here. **Attach receipts.**

Receipt date Day/Mo/Year	Prescription number or description of item	Charge
	Total	

8. **All Dependent** expenses should be listed here. **Attach receipts.**

Receipt date Day/Mo/Year	Dependant's name	Prescription number or description of item	Charge
		Total	

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife Financial ("Manulife") and/or its authorized representative to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their information for the Purposes. **I authorize** any person or organization with information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife and/or its authorized representative, its reinsurers and/or its service providers, for the Purposes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/groupbenefits, or from my plan administrator.

_____ _____

Plan Member's Signature **Date**

Any information provided to or collected by Manulife and/or its authorized representative in accordance with this authorization, will be kept in a Group Benefits health file. Access to your information will be limited to:

- Manulife employees, authorized representatives, reinsurers and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

SUBMIT CLAIM FORM TO:

EMPLOYEE BENEFIT PLAN SERVICES
45 McIntosh Drive
Markham, Ontario L3R 8C7

(905) 946-9700
1-800-263-3564