

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 NA			NAME			CERTIFICATE NUMBER/SIN			
Address		GENDER		LANGUAGE	DATE OF BIRTH				
				Male	English	(MM/DD/	YY)		
		T		Female	French				
Сіту		PROVINCE PO		OSTAL 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 (MM/DD/YY) Date of Service (MM/DD/YY)			Total Charges				
Do you want any unnaid portion of your claim pro	cossed through you	ır Hoalth Sı	nondin	na Accoun	t? Vos	No			
To Assign Payment to Supplier:	Do you want any unpaid portion of your claim processed through your Health Spending Account? Yes No								
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/Y	Y)		



Phone (780) 452-5161

Ellement Consulting Group 1050-11150 Jasper Ave NW Edmonton AB, T5K 0C7 Toll free: 1-800-770-2998

Fax (780) 452-5388

PHYSICIAN'S RECOMMENDATION

(FOR MAJOR MEDICAL SUPPLIES)

Patient's Name								
Recommended medical item(s) – describe in detail including specifications when available Indicate activities requiring this item								
Condition of patient:	Acute		Chronic		Palliative			
Date patient first consulted	d you for this conc	lition (mont	h/day/year)		-			
b. Are you actively treating tr	nis patient for this	condition	Yes	No	If no, please provide comments			
To the best of your knowledge, wh	at is the duration	for use of the	ne recomme	ended ite	em(s)			
For hospital beds only, please indi-	cate the hours or	percentage	of time in b	ed				
For replacement of a prosthesis or	· other equipment,	, please pro	vide:					
a. Date of prior replacement	(MM/DD/YY)				· · · · · · · · · · · · · · · · · · ·			
b. Reason for replacement_								
. Is the device(s) and/or medical equ	uipment required:							
		Yes	No					
	icle accident?	Yes Yes	No No					
, , , ,	government fundi		Yes	No	If no, please give reason			
ian's Name	Physician's	Signature			General Practitioner Specialist			
MM/DD/YY)	Phone Num	ber						
sary for the purpose of settlement of this claim and to administe tant for the purpose of settlement of this claim. I understand the that the information given is true, correct and complete to the	ter the group plan. I authorize r he information collected is kept best of my knowledge and that	release of the information of the strict confidence at each of the above	mation contained in to be and used solely fo we expenses are for its	this claim form or the purpose medical treatn	n to the Insurer/Plan Administrator, its authorized representative of assessing the claim and to administer the group benefit pla ment that I and/or my dependents received. I understand that			
ATURE OF MEMBER				DATE	(MM/DD/YY)			
· ·	Recommended medical item(s) — of Indicate activities requiring this item Diagnosis of medical condition with Condition of patient: a. Date patient first consulted b. Are you actively treating the b. Are you actively treating the b. Are you actively treating the for hospital beds only, please indicated for replacement of a prosthesis or a. Date of prior replacement b. Reason for replacement b. Reason for replacement of a motor vehical c. For sports purpose only? It has an application been made for the purpose of settlement of this claim and to administrator, nary for the purpose of settlement of this claim and to administrator in the purpose of settlement of this claim and to administrator in the purpose of settlement of this claim and to administrator in the purpose of settlement of this claim and to administrator in the purpose of settlement of this claim and to administrator in the purpose of settlement of this claim and to administrator in the purpose of settlement of this claim and to administrator in the purpose of settlement of this claim and to administrator in the purpose of settlement of this claim and to administrator in the purpose of settlement of this claim and to administrator in the purpose of settlement of this claim and to administrator in the purpose of settlement of this claim and to administrator in the purpose of settlement of this claim.	Recommended medical item(s) — describe in detail is Indicate activities requiring this item Diagnosis of medical condition with specific reason of the condition of patient: Acute a. Date patient first consulted you for this condition. Are you actively treating this patient for this beat of your knowledge, what is the duration of the for hospital beds only, please indicate the hours or provided the prosthesis or other equipment, a. Date of prior replacement (MM/DD/YY) b. Reason for replacement Is the device(s) and/or medical equipment required: a. As a result of a work related injury? b. As a result of a motor vehicle accident? c. For sports purpose only? Has an application been made for government funding any for the purpose of settlement of this claim. I understand the information objected is kept and for the purpose of settlement of this claim. I understand the information objected is kept and to the purpose of settlement of this claim. I understand the information objected is kept and the information of more correct and complete to the before provided and the information objected is kept and the information objecte	Recommended medical item(s) – describe in detail including sp Indicate activities requiring this item Diagnosis of medical condition with specific reason for recomme Condition of patient: Acute a. Date patient first consulted you for this condition (month b). Are you actively treating this patient for this condition To the best of your knowledge, what is the duration for use of the For hospital beds only, please indicate the hours or percentage For replacement of a prosthesis or other equipment, please pro a. Date of prior replacement (MM/DD/YY) b. Reason for replacement Is the device(s) and/or medical equipment required: a. As a result of a work related injury? Yes b. As a result of a motor vehicle accident? Yes c. For sports purpose only? Yes Has an application been made for government funding? The PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AN y authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organic and for the purpose of settlement of this claim and odminister the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and to the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and the the information collected is kept in strict confidence.	Recommended medical item(s) – describe in detail including specifications Indicate activities requiring this item	Diagnosis of medical condition with specific reason for recommendation of medical Condition of patient: Acute Chronic a. Date patient first consulted you for this condition (month/day/year) b. Are you actively treating this patient for this condition Yes No To the best of your knowledge, what is the duration for use of the recommended ite For hospital beds only, please indicate the hours or percentage of time in bed For replacement of a prosthesis or other equipment, please provide: a. Date of prior replacement (MM/DD/YY) b. Reason for replacement 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 Has an application been made for government funding? Yes No Physician's Signature			

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