



Health Care Spending Account Claim Form

IUPAT Local 177 Welfare Trust Fund

ATTACH THE ORIGINAL RECEIPTS FOR ALL EXPENSES. Receipts will not be returned to you. Copies of receipts are sufficient for income tax purposes or coordination of benefits with other group plans. Your Explanation of Benefits will be available once your claim is processed.

Member Information

Last Name	First Name	Certificate Number	
Mailing Address		City	Province Postal Code
Phone Number	Cell Phone	Email Address	Date of Birth Month Day Year

Patient Information

Is the patient(s) entitled to benefits under any other plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Note: Dependant children must first be claimed under the parent with the earlier date of birth.</i>
If yes, please retain photocopies of all receipts submitted in this claim for submission to secondary carrier. If Ellement Consulting Group is the first payer, please attach all receipts and the co-insurance statement.		
If yes, please indicate the date of birth of the insured:	Month Day Year	

Claim Details

Patient Name (Last, First)	Relationship to Member	Date of Birth	Type of Service	Total Charges
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Month Day Year		
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Month Day Year		
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Month Day Year		
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Month Day Year		

Authorization and Consent

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(s) 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 dependants 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 provider for the entire amount. I agree that a photocopy or electronic copy of this form is as valid as the original.

Month Day Year

Member Signature (must be in ink)

Date Signed



Plan Administrator

Ellement Consulting Group
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