COUGHLIN & ASSOCIATES LTD

PLAN ADMINISTRATOR

P.O.Box 764, Winnipeg, Manitoba, R3C 2L4
(204) 942 - 4438 Toll Free: 1 - (888) - 204 - 1234

Healthcare, Hospital, Vision Claim Form

INSURED MEMBER -- Complete form with all required information

1. Group Plan Name or Plan Sponser _____ Group Policy No. _____ Local Union No. _____
2. Member's Name _____ (First / Last)
3. Member's /SIN/Certificate _____ 4. Member's Date of Birth _____ / _____ / _____ (Day / Month / Year)
5. Member's Address _____ (Street / City / Province / Postal Code / Telephone)
7. Any of these expenses related to a Workers' Compensation Claim? Yes ☐ No ☐ If Yes, Date of Accident _____
8. Are health benefits payable from another group plan? ☐ Yes (Please provide name of employer and name of Group Medical Carrier)

_____ ☐ No If Spouse previously had coverage indicate cancellation date _____

The spouse who is covered by another medical plan must first submit his/her claim to his/her insurer. Afterwards, provide the Plan Administrator with a completed claim form and a copy of the settlement provided by the other carrier. Photocopies of receipts are acceptable for this type of claim. Claims for children must be submitted to the insurer of the parent whose birthday occurs first in the calendar year.

PLEASE ATTACH ORIGINAL RECEIPTS AND COMPLETE ALL INFORMATION. USE A SEPARATE BOX FOR EACH PERSON. INCOMPLETE FORMS AND PHOTOCOPIED/DUPLICATE RECEIPTS CANNOT BE PROCESSED FOR PAYMENT.

Name of Family Member _____

☐ Member ☐ Spouse ☐ Son ☐ Daughter

If spouse or child, indicate Date of Birth _____ / _____ / _____ (Day / Month / Year)

If over 21 is child in school or disabled? ☐ Yes ☐ No

If yes, please provide proof of disability or education institution registration.

PRESCRIPTION DRUG EXPENSES		OTHER MEDICAL EXPENSES (Hospital, Vision, Ambulance etc.)		
Total # of Receipts Submitted	Total $ Amount Submitted	Receipt Date Date/Month/Year	Description of Expenses	Charge
			Total	

GRAND TOTAL (Prescription & Other Medical Expenses) _____

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☐ Member ☐ Spouse ☐ Son ☐ Daughter

If spouse or child, indicate Date of Birth _____ / _____ / _____ (Day / Month / Year)

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GRAND TOTAL (Prescription & Other Medical Expenses) _____

I AUTHORIZE

- my personal physician and any health care professional, public/private health or social services organization, insurer, reinsurer, employer, or other public/private organization or person that has record or knowledge of me or my health, or of any of my minor children being insured or of their health, to give any such personal information to the Plan Administrator/Insurer its reinsurers, or any consumer reporting agency acting on its behalf, for assessment of claims, and benefit administration.
- the Plan Administrator or the Insurer to obtain from and exchange with any of these organizations or persons any such personal information for the same purposes.
- the use of my Social Insurance Number (SIN) for claim identification purposes (Member only) and, as required by law for Income Tax Reporting.

A copy of this authorization shall be as valid as the original

_____ Dated _____
Member's Signature

MAIL THE COMPLETED FORM AND ORIGINAL RECEIPTS TO THE PLAN ADMINISTRATOR'S OFFICE FOR PROMPT PROCESSING