Manulife Financial

For your future™

BAC - Canada Union Local No. 2 (Ontario) Employee Benefit Trust

PLEASE TYPE OR PRINT. YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS HAVE BEEN ANSWERED IN FULL. USE MORE THAN ONE FORM IF NECESSARY.

STATEMENT OF COVERED EXPENSES FOR HEALTH CARE BENEFITS

Employer	Employer Location (City and Province)	Group Number	Account
		4386	01 - 000

Plan Member Name	Plan Member I.D.	Date of Birth
		Month Day Year

Plan Member Address

Number and Street City Province Postal Code

Do you have another plan that provides Health or Dental benefits for you or your dependants? ◯ **No** ◯ **Yes**

◯ **Health only** ◯ **Dental only** ◯ **Both**

If Yes, is the other coverage provided through: ◯ **Manulife Financial** ◯ **Another insurer** **If Manulife Financial, indicate policy number** _____

If claim is for a dependant child, please indicate spouse's date of birth _____

If claim is for child, indicate ◯ Fulltime Student Date enrolled _____ Date completed _____ ◯ Handicapp

Is treatment a result of an occupational injury, or otherwise related to employment? ◯ No ◯ Yes

	FIRST NAME	SEX	DATE OF BIRTH D	M	Y	DATE EXPENSE INCURRED	NAME AND ADDRESS OF SUPPLIER OR PHARMACY	DRUGS: NAME OR D.I.N. OTHER: TYPE OF EXPENSE	AMOUNT CHARGED
PLAN MEMBER									
SPOUSE									
UNMARRIED CHILDREN									

TOTAL CHARGES

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: _____ **Telephone Number:** _____ **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.

Date _____ Signature of Plan Member _____ Telephone Number _____

Date _____ Signature of spouse if claim is to be coordinated with another Manulife Financial plan _____

Please mail form to:
GLOBAL BENEFITS
88 St. Regis Crescent South
Toronto, ON M3J 1Y8
Tel: (416) 635-6000