

# Ironworkers Health and Welfare Trust Fund of Western Canada

Funds Administrative Service Inc.  
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 Edmonton, AB T5K 3T4  
 (780) 452-5161  
 TOLL FREE 1-800-770-2998

## MEDICAL SUPPLIES STATEMENT

POLICY #6115

<b>Member Information</b>		Local Union No		<b>MEMBER – COMPLETE THIS SECTION (PLEASE PRINT)</b>					
Name (Last)		(First)		Sex (circle)		Date of Birth			
				M	F	M	D	Y	
Address (Street)		Prov		Postal Code		Social Insurance Number			
(City)		Prov		Postal Code		Telephone Number			

<b>IF CLAIM IS ON BEHALF OF AN ELIGIBLE DEPENDENT, PLEASE ANSWER THE FOLLOWING</b>											
Dependent Name			STATUS <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD				Sex (circle)		Date of Birth		
							M	F	M	D	Y
If the claim is for a dependent child 18 years of age or older, please indicate: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time								Expected Date of Graduation			
School Name _____								M	D	Y	

### LIST AND ATTACH ALL PAID RECEIPTS OR INVOICES FOR THIS CLAIMANT

ITEM REQUIRED	NAME AND ADDRESS OF SUPPLIER	DATE OF PAID RECEIPT	AMOUNT CHARGED

1. Do you or your dependents have other coverage which may pay a benefit for any of the expenses being claimed here?  Yes  No
2. Are any benefits provided under any other group insurance plan or government agency?  No  Yes – If YES, attach co-insurance statement.  
 If coordination of benefits no longer applies, termination date: \_\_\_\_\_  
 If claim is for dependent child, please indicate spouse's date of birth: \_\_\_\_\_
3. Should you wish direct payment to be made to the Supplier, please enclose an invoice with a breakdown of the items and amounts charged, together with your Signature on this line: \_\_\_\_\_

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.		
Date _____	Member's Signature _____	( ) Telephone Number _____

**HAVE THE REVERSE SIDE OF THIS FORM COMPLETED IF CLAIM IS FOR MAJOR MEDICAL SUPPLIES**

**PHYSICIAN'S RECOMMENDATION  
(For Major Medical Supplies)**

**PLEASE RETURN COMPLETED FORM TO YOUR PATIENT FOR SIGNATURE**

1. Patient's Name \_\_\_\_\_

2. Recommended medical item(s) (Please describe in detail) \_\_\_\_\_

\_\_\_\_\_

3. Diagnosis of medical condition with specific reason for recommendation of medical item(s)

\_\_\_\_\_

4. (a) Date patient first consulted you for this condition \_\_\_\_\_

(b) Are you actively treating this patient for this condition?  YES  NO

If "No", please provide comments \_\_\_\_\_

\_\_\_\_\_

5. To the best of your knowledge, what is the duration for used of the recommended item(s)? \_\_\_\_\_

\_\_\_\_\_

6. For replacement of a prosthesis or other equipment, please provide:

(a) Date of prior replacement \_\_\_\_\_

(b) Reason for replacement \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number

**The patient is responsible for securing this form and any changes made for its completion.**