FORM – F1

UFCW LOCAL 247 BENEFIT TRUST FUND

DRUG, EXTENDED HEALTH CARE ("EHC") & VISION EXPENSES FORM

318B – 2099 LOUGHEED HWY., PORT COQUITLAM BC V3B 1A8
Tel: 604-945-7607 Toll-Free: 1-800-663-7977

INSTRUCTIONS: Attach the original bills and receipts for all expenses and itemize them by providing all the information requested. Note: Drug, Extended Health Care ("EHC") and Vision bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors.

EMPLOYER STORE NO.: _____ ID (SOCIAL INSURANCE NO.): _____

MEMBER'S NAME: _____ DATE OF BIRTH: _____
MM DD YY SEX

ADDRESS: _____ **BC**
NUMBER & STREET CITY PROVINCE POSTAL CODE

Have you any other coverage which would pay a benefit for this claim? Yes No (Circle one)

If "yes" name of Employer, Insurance Co. and Coverage Start Date _____

Date of Purchase mm	dd	yy	Type of Vision or EHC Expense, or Drug Name	Service Provider or Pharmacy	Total Charge	Date of Purchase mm	dd	yy	Type of Vision or EHC Expense, or Drug Name	Service Provider or Pharmacy	Total Charge

(If additional space is needed, attach separate sheet) TOTAL OF ALL CHARGES $_____

CERTIFICATION & CONSENT

I understand that it is an offence to make a false or misleading statement regarding the personal and claims information provided herein and declare that the information is true, correct and complete.

I certify that the charges for the medical services and/or supplies which are identified on this form, and for which receipts are attached, were incurred by me on the recommendation and approval of an attending physician, and were required in connection with the treatment of an injury or illness suffered by me.

I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in strictest confidence and will only be used for the specified purpose.

I understand that my personal information, as provided herein, as well as other personal information currently held or to be collected in the future, is required to: communicate with me; determine coverage and benefit entitlements; process claims for expenses incurred; satisfy any reporting requirements of the provincial and federal governments; comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan.

I hereby authorize the Board of Trustees and the service agencies they employ to collect, record, use, disclose and, if applicable, destroy my personal information. I may review the information, referenced herein, to ensure that it is up-to-date, and that I may withhold or revoke my consent for its use, at any time. However, I realize that if I withhold or revoke my consent for its use, thereby limiting or restricting the ability to determine coverage and benefit entitlements, my participation in the Plan may be impaired or cancelled.

If I have coverage under another plan, I hereby authorize the Plan Sponsor to disclose personal information about me in order to determine eligibility for coverage in the settlement of claims.

_____
Email Address

_____ _____ _____
Date Signature of Member Telephone Number

ADMINISTRATOR'S SECTION – FOR OFFICE USE ONLY

COVERED MEMBER'S EFFECTIVE DATE: _____ _____
Initials & Date

POSSESSION OF THIS CLAIM FORM DOES NOT CONSTITUTE ELIGIBILITY FOR BENEFITS

Revised July 2019