# UNIFOR LOCAL 2002 HEALTH & WELFARE TRUST FUND

## STATEMENT OF COVERED EXPENSES FOR HEALTH SPENDING ACCOUNT BENEFITS
**ONLY EXPENSES INCURRED ON OR AFTER AUGUST 1, 2019 TO JULY 31, 2020 ARE ELIGIBLE**
**CLAIMS MUST BE RECEIVED IN THE OFFICE OF THE PLAN ADMINISTRATOR, CANADIAN BENEFITS BY 12:00 NOON (EST) JULY 31, 2020**
**(MAXIMUM CREDITS (AMOUNT) IS $200 FOR FULL-TIME AND $100 FOR PART-TIME)**

**TO BE COMPLETED BY MEMBER:** **Staple original receipts for each expense claimed. Return claim to your Plan Administrator. All eligible expenses under your Group Benefit Plan MUST first be submitted to your Group Insurance Plan Carrier**
**To claim any unpaid portion of your claim, you must submit a copy of your original receipts along with a Statement clearly showing "DATE OF SERVICE" from Claims Secure (My eProfile - Claims; My eProfile - View Claims Details) or Sun Life (Statement of Claim)**

| MEMBER'S NAME | EMPLOYEE NO. | DATE OF BIRTH Day Month Year | SEX |
|---|---|---|---|
| | | | |

| MEMBER'S ADDRESS NO. AND STREET | CITY | PROVINCE | POSTAL CODE |
|---|---|---|---|
| | | | |

MEMBER'S EMAIL ADDRESS:

Please indicate your current status: ☐ Full-time ☐ Part-time
Are health benefits payable from another group plan? ☐ Yes ☐ No
If 'yes': Attach copies of Receipts along with a copy of Statement of Benefit Payment issued by the insurance company
If claim is for a child and over the age of 18 please provide a copy of current school year registration form
If claim is for a 'parent' please provide a copy of your most recent Income Tax Form

| | FIRST NAME | SEX | BIRTHDATE D M Y | DATE EXPENSE INCURRED | DRUGS: NAME OR D.I.N. OTHER: TYPE OF EXPENSE | AMOUNT CHARGED |
|---|---|---|---|---|---|---|
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FOR DIRECT DEPOSIT OF HSA BENEFITS

Please enclose a void cheque or complete the information below.

**PLEASE NOTE THAT REIMBURSEMENT WILL BE DIRECT DEPOSIT ONLY (NO REIMBURSEMENT CHEQUE WILL BE ISSUED)**


**Canadian Benefits Consulting Group Limited**

Canadian Benefits Consulting Group Limited is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with medical treatment of the above named individuals. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. I authorize any physician, dentist or any health care provider and/or facility, any insurance company, benefit service provider and any other person or organization having any medical or other relevant personal information regarding me or my spouse and/or dependant to release to and exchange with the Plan Sponsor, Canadian Benefits or their representatives and/or agents any and all information necessary to investigate and confirm the accuracy and validity of this claim. I confirm that I am authorized to act on behalf of my spouse and/or dependants for such purposes. I authorize the use of my identification number and administration of any benefits and understand that the provision of my identification for such purposes is optional and not a condition of service and that I have the option of refusing or withdrawing my authorization. Any copy of this authorization shall be valid as the original.

DATE: _____ MONTH _____ YEAR _____ MEMBER'S SIGNATURE: _____

**Administrator:**

Canadian Benefits CONSULTING GROUP

**Please submit claims to:**

2300 Yonge Street , Suite 3000, PO 2426, Toronto, Ontario M4P 1E4
(416) 488-7755 1-800-268-0285
Fax: (416) 488-7774 / Email: gidip@canben.com

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