UNIFOR LOCAL 2002 HEALTH & WELFARE TRUST FUND

STATEMENT OF COVERED EXPENSES FOR HEALTH SPENDING ACCOUNT BENEFITS

ONLY EXPENSES INCURRED ON OR AFTER AUGUST 1, 2023 TO JULY 31, 2024 ARE ELIGIBLE

CLAIMS MUST BE RECEIVED IN THE OFFICE OF THE PLAN ADMINISTRATOR, CANADIAN BENEFITS BY 12:00 NOON (EST) JULY 31, 2024

(MAXIMUM CREDITS (AMOUNT) IS $300 FOR FULL-TIME AND $150 FOR PART-TIME)

TO BE COMPLETED BY MEMBER:

Attach receipts for each expense claimed.

All eligible expenses under your Group Benefit Plan MUST first be submitted to your Group Insurance Plan Carrier The statement from you Group Carrier must clearly indciate:

"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	
MEMBER'S ADDRESS NO. AND STREET	CITY	PROVINCE	POSTAL CODE
MEMBER'S EMAIL ADDRESS:			

Please indicate your status at July 31, 2023: ☐ 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

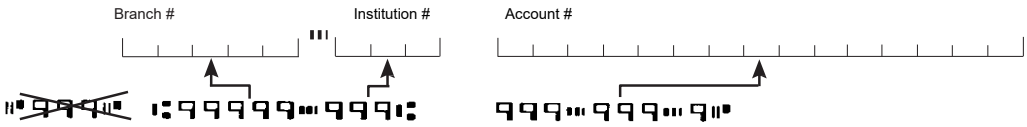
If claim is for a 'parent' please provide a copy of your most recent Income Tax Form

	FIRST NAME/ RELATION	BIRTHDATE D M Y	DATE EXPENSE INCURRED	DRUGS: NAME OR D.I.N. OTHER: TYPE OF EXPENSE	AMOUNT CLAIMED

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



Canadian Benefits Consulting Group

Canadian Benefits Consulting Group 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: _____**

Please submit claims to:

(416) 488-7755 1-800-268-0285

Fax: (416) 488-7774 / Email: gidip@canben.com

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