

HEALTH CARE EXPENSES STATEMENT

Policy #115HW

Send all claims & inquiries to:

Quinte St. Lawrence Health & Welfare Plan

40 Binnington Ct.

Kingston, ON; K7M 8S3 613-547-4115 Toll Free #1-800-631-3207

Faxed Claim Forms are Unacceptable

Original Receipts are always required

1. MEMBER INFORMATION

Complete in Full Where Necessary

Member's Name	Date of Birth
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Address of Employee _____



Check if New Address

2. DEPENDANT INFORMATION

(Complete in full or claim will NOT be paid)

(Complete only for Dependants you are claiming for)	Dependant's Name	Date of Birth	Relationship to Insured

If Claiming for a Dependant who has other Insurance, you must send claims to his/her other insurance prior to making a claim through Local 115 IBEW.

3. PRESCRIPTION DRUG EXPENSES

All prescription drugs are paid through ESI.

Manual Claims - If you did not use your drug card, please indicate the reason below and attach all original receipts. Without sufficient cause, reimbursement is subject to 5% co-insurance for Manual submissions and reimbursement will only be processed on the 20th of the month.

4. MISCELLANEOUS HEALTH CARE EXPENSES-Itemize and Attach All Detailed Receipts

5. VISION CARE EXPENSES

(Attach Detailed Paid In Full Receipt with Cost Breakdown)

Date of Purchase: _____

You must provide a paid in full receipt confirming the purchase of Prescription Eyewear.

Complete the following section only if the Receipt does not provide a cost breakdown.

Cost of Lenses	_____	Single	Bifocal	Trifocal	Contact Lenses
Cost of Frames	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dispensing Fees	_____				
Other Fees (describe)	_____	(CHECK ONE ONLY)			
Total Discount (if applicable)	_____				

6. CO-ORDINATION OF BENEFITS-Attach copies of reimbursement from other insured

This area must be completed in full:

Are Group Benefits payable from any other source for this Claim? YES NO Check one

If yes, Name of Group & Policy Number _____

Name & Date of Birth of other Insured Person _____

Name of Insurer (Insurance Company) _____

7. AUTHORIZATION

I declare the above information is complete and true. I authorize every one concerned to divulge to my insurer all particulars pertaining to this claim. I authorize the use of my Social Insurance Number for identification purposes.

Date _____

Member's Signature _____

Date Paid _____ Cheque # _____ Authorization _____