



Send all claims & enquiries to:  
 Coughlin & Associates Ltd., Plan Administrator  
 P.O. Box 764, Winnipeg, Manitoba, R3C 2L4  
 (204) 942-4438 Toll Free: 1(888)204-1234

# HEALTHCARE, HOSPITAL, VISION CLAIM FORM

**NOTE: Attach all original bills and receipts for which a claim is being made. Incomplete information will delay processing of this claim.**

<p><b>INSURED MEMBER</b> complete this section. Please print.</p> <p>Group Plan Name: <u>Iron Workers (Manitoba) L.U. 728</u></p> <p>Group Policy Number: <u>240119</u></p> <p>Name: _____</p> <p>Address: _____</p> <p>Postal Code _____ Phone No. ( ): _____</p> <p>MEMBER'S S.I.N. # <input type="text"/> - <input type="text"/> - <input type="text"/></p> <p>Patient(s) Name: _____</p> <p>Relationship to Insured Member: _____</p> <p>Date(s) of Birth _____ Gender(s) _____</p> <p>Note: If dependant age 21 or over indicate        STUDENT <input type="checkbox"/> HANDICAPPED <input type="checkbox"/></p> <p>If a dependant claim, school information is required only for dependant children age 21 and over.        (Please provide proof of student attending Educational Institution.)</p>	<p>Are any benefits or services provided under any other Group Insurance Plan?        Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, indicate who is insured under the other Plan. Self <input type="checkbox"/> Spouse <input type="checkbox"/></p> <p>If spouse, please provide spouse's date of birth _____</p> <p>Effective date of coverage _____</p> <p>Name of Insurer _____ Policy No. _____</p> <p>* NOTE: For coordination of benefits, dependent children must be claimed under the Plan of the parent with the earlier day and month of birth, in the calendar year.</p> <p><b>ACCIDENT INFORMATION</b></p> <p>Are any of the expenses being claimed due to an accident? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, did the accident happen at work? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Please provide a letter: * explaining the details of the accident and * indicating if another party is liable</p> <p>Date of accident _____</p> <p><input type="checkbox"/> Please check if address has changed in past 12 months</p>
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**A. PRESCRIPTION DRUG CHARGES** Check if Applicable

- ORIGINAL RECEIPTS SHOWING PATIENT NAME, PRESCRIPTION NUMBER, NAME OF DRUG, DATE OF BILL AND AMOUNT MUST BE ATTACHED

**B. HOSPITAL CHARGES** Check if Applicable

- The hospital will complete their standard claim form upon request.
- Attach the form and submit to the ADMINISTRATOR'S OFFICE SHOWN ABOVE.

**C. OTHER MEDICAL CHARGES** (e.g. ambulance, paramedical, etc.)

DESCRIPTION	CHARGED BY NAME AND ADDRESS	DATE SHOWN ON BILL DAY-MONTH-YEAR	AMOUNT	PATIENT

**D. VISION CARE CHARGES** (Original receipt must be attached)

Patient \_\_\_\_\_

Date of Service \_\_\_\_\_

Charges for:	Amount
___ Examination Yes <input type="checkbox"/> No <input type="checkbox"/>	\$ _____
___ Lenses Single <input type="checkbox"/> Bifocal <input type="checkbox"/> Other <input type="checkbox"/>	\$ _____
Is this a change in prescription? Yes _____ No _____	
___ Frames	\$ _____
___ Contact Lenses	\$ _____
Total \$	\$ _____

\_\_\_\_\_  
Optometrist's Signature

**MEMBER DECLARATION**

The information on this form is true and complete to the best of my knowledge. I authorize the use of my social insurance number for identification purposes and as required by law, for Income Tax reporting. I authorize the release to and use by Coughlin & Associates Ltd. any medical or other information that may be required to establish the validity of this claim and further empower said Company to disclose any personal or claims information needed for medical case review or study. A photocopy of this release shall be as valid as the original.

Date \_\_\_\_\_

Insured Member's Signature \_\_\_\_\_

**E. HEALTHCARE SPENDING ACCOUNT**

The Plan has recently revised its procedures whereby any remaining Health or Dental benefit expenses not covered by the basic Plan (i.e. deductibles, claims that have exceeded an allowable maximum, etc.) are now automatically applied to the extent of your Healthcare Spending Account, if any, unless you indicate otherwise below. The exception would be in instances of co-ordination of benefits with your Spouse's Plan.  Do not apply remaining claims expenses automatically to my H.S.A.

I authorize Coughlin & Associates Ltd. to collect and exchange personal information about me and/or my dependants to process this claim and administer my group plan. I authorize Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits; Coughlin to exchange my personal information with the following persons, organizations or parties; Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled. When providing personal information for my spouse and/or dependants, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorizations & Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge

Date  /  /  Plan Member's Signature \_\_\_\_\_

Protecting your personal information The administrator of your group benefit plans is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law