THE Great-West Life ASSURANCE COMPANY

STATEMENT OF COVERED EXPENSES FOR SUPPLEMENTARY HEALTH BENEFITS

B.M.I.U. OF CANADA LOCAL 1
L.I.U.N.A. LOCAL 183

MAIL ALL CLAIMS TO: **LOCAL 183 TRUST ADMINISTRATION**
1263 WILSON AVENUE, SUITE 205
NORTH YORK, ONTARIO M3M 3G2

CLAIM ENQUIRIES: **416.240.7487**

Please type or print, including all information indicated. Use more than one form if necessary.

Employer		Employer location (city and prov.)	
Member's Name	Policy No.	Identification No.	Date of Birth Mo. Day Yr.
Member's Address No. and Street City Prov. Postal Code		Telephone Number	☐ Initial Claim ☐ Subsequent Claim

Have you (or your dependant) any other coverage which would pay a benefit for this claim? ☐ Yes ☐ No

If "Yes", policy number _____ and name of insuring agency _____

If "Yes" and claim is for a dependent child, please indicate spouse's date of birth _____

If child, indicate ☐ student ☐ handicapped

	FIRST NAME	SEX	DATE OF BIRTH D	M	Y	DATE EXPENSE INCURRED	NAME AND ADDRESS OF SUPPLIER OF PHARMACY	DRUGS: NAME OR D.I.N. OTHER: TYPE OF EXPENSE	AMOUNT CHARGED
MEMBER									
SPOUSE									
UNMARRIED CHILDREN									

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Plan Member's Signature _____ Date _____

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL

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