canada life™

STATEMENT OF COVERED EXPENSES
FOR SUPPLEMENTARY HEALTH BENEFITS
LiUNAcare LOCAL 183

MAIL ALL CLAIMS TO: *LiUNAcare LOCAL 183*
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	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 Canada 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. I authorize Canada Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com

Plan Member's Signature _____ Date _____

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

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Clear