



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>INSURED MEMBER complete this section. Please print.</p> <p>Group Plan Name: <u>IBEW Local 2038</u></p> <p>Group Policy Number: <u>24979</u></p> <p>Name: _____</p> <p>Address: _____</p> <p>Postal Code _____ Phone No. () _____</p> <p>MEMBER'S S.I.N. # - - </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 D M Y</p> <p>Effective date of coverage D M Y</p> <p>Name of Insurer _____ Policy No. _____</p> <p><small>* 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.</small></p> <hr/> <p>ACCIDENT INFORMATION</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 Day Month Year</p> <p><input type="checkbox"/> Please check if address has changed in past 12 months</p>
--	---

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 Members Signature _____

E. HEALTHCARE SPENDING ACCOUNT

Any amount not eligible for reimbursement from the contents of this claim (e.g. deductible and co-insurance payment, claim that has exceeded an allowable maximum, health and dental expenses not covered under group insurance plan, etc.) is to be automatically applied to the extent of the balance in my Health-care Spending Account, if any. YES NO