THE MANUFACTURERS LIFE INSURANCE COMPANY

Mail all claims to:
LABOURERS' LOCAL 837
44 HUGHSON STREET SOUTH
HAMILTON, ONTARIO L8N 2A7
If you have any questions please call 905 529-1116

LABOURERS' UNION LOCAL 837 HEALTH AND WELFARE FUND

CLAIM FOR SUPPLEMENTARY HEALTH CARE BENEFITS

PLEASE USE WHEN SUBMITTING ALL FUTURE CLAIMS (EXCEPT DENTAL)

(Attach All Receipts)

PLEASE TYPE OR PRINT. INCLUDE ALL INFORMATION INDICATED. USE MORE THAN ONE FORM IF NECESSARY.

50124

Plan Member's Name	Identification Number	Date of Birth Month Day Year
Plan Member's Address Number and street City Province Postal code		☐ Initial Claim ☐ Subsequent Claim

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

If "Yes", name of employer and insurance company. _____

If claim is for a dependant child please indicate spouse's date of birth _____ .

Dependant Name	Relationship	Date of Birth

Date expense incurred	Name of doctor or pharmacy	Drugs: Name or D.I.N. Other: Type of expense	Amount charged

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife Financial ("Manulife") and/or its authorized representative to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their information for the Purposes. **I authorize** any person or organization with information including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife and/or its authorized representative, its reinsurers and/or its service providers, for the Purposes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/groupbenefits, or from my plan administrator.

Plan Member's Signature _____ Date (Day / Month / Year) _____ Telephone number _____

Any information provided to or collected by Manulife and/or its authorized representative in accordance with this authorization, will be kept in a Group Benefits health file. Access to your information will be limited to:

- Manulife employees, authorized representatives, reinsurers and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.