Manulife Financial

For your future™

Major Medical
Statement of Claim

Member – complete this section. Please print.

SHEET METAL WORKER'S UNION LOCAL 285 EMPLOYEE BENEFIT TRUST

1. Member's name _____ Date of birth ____/____/____ (Day / Month / Year)

2. Address _____ (Street) Identification No. _____

_____ (City / Province) Postal Code _____

3. Is this your first claim with Manulife Financial? ☐ Yes ☐ No

4. If you are making a claim for a Dependant, please provide the following information:

First name of dependant	Dependant's date of birth (Day Mo. Yr.)	Relationship (Spouse/Child)	Is Dependant working? (Yes or No)	Is Dependant in school? (Yes or No)	If working, provide name of employer If in school, provide name of institution
	/ /				
	/ /				
	/ /				
	/ /				

5. Are group health benefits payable from any other source? ☐ Yes ☐ No Name source _____

6. Name and address of prescribing physician(s). _____

7. **All Member** expenses should be listed here. **Attach receipts.**

Receipt date Day/Mo/Year	Prescription number or description of item	Charge
	Total	

8. **All Dependent** expenses should be listed here. **Attach receipts.**

Receipt date Day/Mo/Year	Dependant's name	Prescription number or description of item	Charge
		Total	

I authorize Manulife Financial and/or its authorized representative to collect, use and disclose personal information concerning me and/or my dependant(s) (where applicable) for the purpose of determining eligibility for Manulife Financial products and services; underwriting and administration of coverage; the adjudication and payment of claims and other relevant purposes all of which are described in more detail in Manulife Financial's Privacy Policy and Privacy Information Package, available at www.manulife.ca or by request.

I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

_____

Signature of Plan Member (in full) **Date**

Member – submit completed claim form to:

GLOBAL BENEFITS
88 St. Regis Crescent South
Toronto, ON
M3J 1Y8
Tel: (416) 635-6000

For Plan Administrator Use Only – do not write in this area.

Group policy number - **901776** Member's effective date ____/____ (Month / Year)

If Member's coverage has terminated, give date ____/____ (Month / Year)

In Benefit:	Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
☑ YES													
☒ NO													

_____ Signature Verifying Eligibility _____ Date