Manulife Financial

STATEMENT OF COVERED EXPENSES FOR SUPPLEMENTARY HEALTH BENEFITS

INTERNATIONAL UNION OF PAINTERS AND ALLIED TRADES WELFARE FUND

MAIL ALL CLAIMS TO: **IUPAT Benefit Trust Administration**
P. O. Box 1280, Station B
Mississauga, ON L4Y 3W5

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

SF-6122

Company Name	Local Number

Member's Name	Identification No.	Date of Birth Mo. Day Yr.

Member's Address
No. and Street City Prov. Postal Code

☐ Initial Claim
☐ Subsequent Claim

Is this a change of address from your last claim submission? ☐ Yes ☐ No If yes, please advise effective date of change _____ mm/dd/yy

PLEASE NOTE ALL FUTURE IUPAT BENEFIT TRUST CORRESPONDENCE WILL BE DIRECTED TO THE ABOVE ADDRESS.

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

If yes, provide name of Employer and Insurance Company _____

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

Are expenses related to an accident? ☐ Yes ☐ No

Are expenses related to W.C.B. case? ☐ Yes ☐ No

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

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: _____ **Telephone Number:** _____ **Date:** _____

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.

POSSESSION OF THIS CLAIM FORM DOES NOT CONSTITUTE ELIGIBILITY FOR BENEFITS