

# BOILERMAKERS LODGE 359 HEALTH AND WELFARE FUND

## Major Medical Benefit Claim Form

### Member's Personal Information - Complete this section, Please print

1. Member's Name \_\_\_\_\_ Date of Birth Mo. / Day / Yr. \_\_\_\_\_

2. Address \_\_\_\_\_ S.I.N. 

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 \_\_\_\_\_

\_\_\_\_\_ Postal Code \_\_\_\_\_

Is this a new address? Y  or N

Is this a temporary address? Y  or N

3. If you are making a claim for a Dependent, please provide the following information:

First Name of Dependent	Dependent's Date of Birth	Relationship (Spouse/Child)	Is Dependent Working? (Yes or No)	Is Dependent in School? (Yes or No)	If working, provide name of employer If in school, provide name of School
_____	Mo. / Day / Yr.	_____	_____	_____	_____
_____	Mo. / Day / Yr.	_____	_____	_____	_____
_____	Mo. / Day / Yr.	_____	_____	_____	_____
_____	Mo. / Day / Yr.	_____	_____	_____	_____

4. Are benefits payable from any other plan?  Yes  No Name of the other plan \_\_\_\_\_

Who is the person insured under the other plan? \_\_\_\_\_

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

**All Dependent** expenses should be listed here. Use one box for each Dependent. There are other boxes on the other side of this form. **Attach receipts**

Nature of illness \_\_\_\_\_

Dependent's Name \_\_\_\_\_  
Nature of illness \_\_\_\_\_

Receipt Date Mo./Day/Year	DIN or Drug Name or Description of Item	Charge
<b>Total</b>		

Receipt Date Mo./Day/Year	DIN or Drug Name or Description of Item	Charge
<b>Total</b>		

I hereby certify that each of the above listed drugs or expenses was purchased or incurred in connection with the medical treatment of the above named individuals. I authorize the use of my Social Insurance Number (SIN) for claim identification purposes only.

Member's signature \_\_\_\_\_ Date \_\_\_\_\_

**Member - submit completed claim form to**

Boilermakers Benefit Plans  
Administration Office  
c/o MEBS  
302 - 3602 Gilmore Way  
Burnaby BC V5G 4W9

**PRIVACY STATEMENT**

The Benefit Plan will collect, maintain and communicate only the Personal Information considered necessary for the effective administration of the Plan. Personal Information will be protected pursuant to the relevant privacy legislation. The Plan may use and exchange information with relevant third parties or organizations (unions, health professionals, institutions, investigative agencies, insurers, re-insurers, regulators) in order to manage the Plan and your entitlement to the Benefits under the Plan. If you have any questions, please ask the administrator.



