Manulife Financial

ROOFERS (LOCAL 30) BENEFIT TRUST FUND
GROUP POLICY NUMBER 901886

Major Medical - Statement of Claim

Member - complete this section. Please print.

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

2. Address _____ S.I.N. ☐☐☐☐☐☐☐☐☐
   Street
   _____ Postal code _____
   City Province

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 / Month / Year)	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/Month/Year	Prescription number or Description of item	Charge
	Total	

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

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

I authorize The Manufacturers Life Insurance Company ("Manulife Financial") to collect and exchange personal information about me and/or my dependants to process this claim and administer my group plan. I understand any personal information obtained by Manulife Financial will be kept confidential and, where necessary, Manulife Financial will be exchanging my personal information. I authorize the following persons to exchange with Manulife Financial or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, insurance broker or plan administrator, my employer or former employer, government agency, auditing or independent investigative organization, and financial institution.

I authorize the use of my Social Insurance Number for identification purposes. 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.

Plan Member Signature (in full) Date

Member — submit completed claim form to:

Employee Benefit Plan Services Ltd.,
45 McIntosh Drive
MARKHAM ONTARIO L3R 8C7
(905) 946-9700
1-800-263-3564