UNITE HERE HEALTH & WELFARE PLAN
Administered by
SoBen Ltd.
150 Consumers Road, Suite 302, Toronto, Ontario M2J 1P9
Tel: 416-498-8338 Toll Free: 1-888-887-6879 Fax: 416-498-4591

MEDICAL FORM

(For Prescription Drugs, Hospitalization, Ambulance, Orthotics, Vision Care and other medical expenses.)

EMPLOYEE INFORMATION:

Last Name: ______________________________ First Name: ____________________________ Male ☐ Female ☐

Address: ____ Apt. No.: ________ S.I.N. No.: _________________

City: _______________________ Province: ________ Postal Code: ______________ Home Tel.: ________________

EMPLOYMENT INFORMATION:

Place of Work: ____ Department: ________________________

Address: ____ Bus. Tel.: ________________________

City: _______________________ Province: ________ Postal Code: ______________ Ext.: ________________

COORDINATION OF BENEFITS: (To be filled out ONLY if spouse has other insurance coverage)

Spouse's Insurance Company: ____ Policy No.: _______________________

Spouse's Date of Birth (dd/mm/yy): _______________________ Your Date of Birth (dd/mm/yy): __________________

CLAIMS DETAILS: Total number of receipts attached with this claim form: ____________

a. Attach an original paid receipt for every expense claimed.
b. List all the dependents you are claiming expenses for, other than yourself.
c. Claims for dependent children over 21 years old should include statement of current year tuition payment.

	Name	Age	Relationship to employee
1.	___________________________________	__________	____________________
2.	___________________________________	__________	____________________
3.	___________________________________	__________	____________________
4.	___________________________________	__________	____________________

I hereby certify that the above information is true and that these expenses were incurred for the exclusive use of the person(s) named above. I authorize any medical practitioner, hospital, employer, UNITE HERE Local 75, drug card provider and insurance company to release to the UNITE HERE Health & Welfare Plan and its agents any information relevant to this claim. I authorize the UNITE HERE Health & Welfare and Pension Plans and their agents to use my social insurance number for identification purposes and to use any of the information provided, for the purpose of administering the benefit plans.

Date: ________________________________ Signature: ____