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

MEDICAL CLAIM FORM

PLAN MEMBER INFORMATION:

Last Name: _____ First Name: _____

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): _____

CLAIM 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: _____