UFCW – CANADA SAFEWAY LIMITED PART-TIME EMPLOYEE BENEFIT PLAN
(ALBERTA)
DRUG AND VISION EXPENSES FORM

INSTRUCTIONS: Please answer all questions. Attach original bills and receipts for all expenses and itemize them by providing all the information requested. Note: Drug and vision bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

IMPORTANT: Only those expenses received by the Administrator within twelve (12) months of the date the expense was incurred are eligible for reimbursement. This claim will be returned to you if it is incomplete or contains errors, or the certification page is unsigned.

Please Print

MEMBER'S STATEMENT

PLAN NUMBER	EMPLOYER/STORE #	MEMBER'S NAME
843		

SOCIAL INSURANCE NUMBER

DATE OF BIRTH: DAY / MONTH / YEAR

PHONE NUMBERS
HOME: ( ) -
WORK: ( ) -

ADDRESS: NUMBER AND STREET TOWN PROVINCE POSTAL CODE

COORDINATION OF BENEFITS

Are you or any other people in your family entitled to benefits under any other plan? Yes ☐ No ☐

If "Yes", name the person so insured: _____ Relationship to Member: _____

Name of other insurance company: _____ Policy Number: _____

SEND CLAIM TO:

UFCW – Canada Safeway
Part-Time Benefit Plan
101 - 46 Hopewell Way NE
Calgary, Alberta
T3J 5H7

403-250-3534
1-866-544-9686

Is any other person in your family (other than yourself) insured as a Member under this plan? Yes ☐ No ☐

If "Yes" to either question above, and the patient is a dependent child, please provide spouse's date of birth: _____ / _____ / _____ (Day / Month / Year)

Is treatment required as the result of an accident? Yes ☐ No ☐ If "Yes", give date, location and explain how accident happened:

_____

Is a claim being made for Workers' Compensation Benefits through WCB? Yes ☐ No ☐

DEPENDENT INFORMATION

Patient Name	Relationship to Member	Date of Birth Day	Month	Year	Does patient reside with you? Yes	No	Full-Time Student? Yes	No	If child over 18 years: If Student, how many hours per week?	Employed? Yes	No	How many hrs worked per week?

CLAIM DETAILS

Patient Name	DATE EXPENSE INCURRED Day	Month	Year	OTHER INFORMATION: Type of Vision Expense, Drug Name, or Drug Identification Number	Pharmacy or Vision Care Provider	Total Charge

(If additional space is needed, attach separate page)

IMPORTANT: Please see reverse side for Certification and Consent.

CERTIFICATION AND CONSENT

I understand that it is an offense to make a false or misleading statement regarding the personal and claims information provided herein and declare that the information is true, correct and complete.

I certify that the charges for the medical services and/or supplies which are identified on the reverse side of this form, and for which original receipts are attached, were incurred by me, or on behalf of one of my eligible dependents, on the recommendation and approval of an attending physician, and were required in connection with the treatment of an injury or illness suffered by me or one of my eligible dependents.

I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in strictest confidence and will only be used for the specified purposes.

I understand that my personal information, and that of my dependents under 18 years of age, as provided herein, as well as other personal information currently held or to be collected in the future, is required to: communicate with me; determine coverage and benefit entitlements; process claims for expenses incurred; satisfy any reporting requirements of the provincial and federal governments; comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan.

I hereby authorize the Board of Trustees and the service agencies they contract to collect, record, use, disclose and, if applicable, destroy my personal information and that of my dependents who are under 18 years of age. I understand that all personal information will be kept confidential and secure, and that it will only be used for the purposes identified herein. Also, I understand that I may review the information, referenced herein, for myself or my dependents, who are under 18 years of age, to ensure that it is up-to-date, and that I may withhold or revoke my consent for its use, at any time. However, I realize that if I withhold or revoke my consent for its use, thereby limiting or restricting the ability to determine coverage and benefit entitlements, my participation in the Plan may be impaired or cancelled.

If I, or my dependents under 18 years of age, have coverage under another plan, I hereby authorize the Trustees to disclose personal information about me, and my dependents, in order to determine eligibility for coverage in the settlement of claims.

A photocopy of this authorization will be as valid as the original.

_____ _____

Signature of Plan Member Date

If an expense has been incurred by your eligible spouse, and is attached to this claim, please have your spouse sign the following.

I hereby consent to the collection, recording, use, disclosure and, if applicable, destruction of my personal information in the same manner as described above.

_____ _____

Signature of Spouse Date

If an expense has been incurred by an eligible dependent child age 18 or older, and is attached to this claim, please have your child sign the following.

I hereby consent to the collection, recording, use, disclosure and, if applicable, destruction of my personal information in the same manner as described above.

_____ _____

Signature of Dependent Child Age 18 or Over Date