Operating Engineers of Manitoba
Local 987

Healthcare, Hospital, Vision Claim Form

Send all claims & enquires to:

COUGHLIN
employee benefits specialists

Plan Administer
P.O. Box 764, Winnipeg, Manitoba, R3C 2L4
(204) 942-4438 Toll Free: 1 (888) 204-1234

INSURED MEMBER complete this section. Please print.

Group Plan Name: Operating Engineers of Manitoba Local 987

Group Policy Number: 901837

Name: _____

Address: _____

_____

Postal Code_____ Phone No. ( ): _____

MEMBER'S S.I.N. # | | | |

Patient(s) Name: _____

Relationship to Insured Member: _____

Date(s) of Birth _____ Gender(s) _____

Note: If dependent age 21 or over indicate

STUDENT ☐ HANDICAPPED ☐

If a dependent claim, school information is required only for dependent children age 21 and over.

Please provide proof of student attending Educational Institution.

Are any benefits or services provided under any other Group Insurance Plan? Yes ☐ No ☐

If yes, indicate who is insured under the other Plan. Self ☐ Spouse ☐

If spouse, please provide spouse's date of birth. ___ ___ ___ D M Y

Effective date of coverage ___ ___ ___ D M Y

Name of Insurer_____ Policy No. _____

*NOTE: For coordination of benefits, dependent children must be claimed under the Plan of the parent with the earlier day and month of birth, in the calendar year.

ACCIDENT INFORMATION

Are any of the expenses being claimed due to an accident? Yes ☐ No ☐

If yes, did the accident happen at work? Yes ☐ No ☐

Please provide a letter: * explaining the details of the accident and * indicating if another party is liable

Date of accident ___ ___ ___ Day Month Year

☐ Please check if address has changed in past 12 months

PRESCRIPTION DRUG CHARGES / HOSPITAL CHARGES OTHER MEDICAL CHARGES (e.g. ambulance, paramedical)

Original receipts showing prescription number, name of drug, date of bill and amount must be attached.

Receipt Date Day/Mo/Year	Prescription Number or Description of Item	Charge
	Total	

VISION CARE CHARGES

Original receipts must be attached

Patient _____

Date of Service _____

Charges for: Amount

— Examination Yes ☐ No ☐ $ _____

— Lenses ☐ Single ☐ Bifocal ☐ Other $ _____

Is this a change in prescription? Yes ___ No ___

— Frames $ _____

— Contact Lenses $ _____

Total $ _____

I authorize Coughlin & Associates Ltd. to collect and exchange personal information about me and/or my dependants to process this claim and administer my group plan. **I authorize** Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits; Coughlin to exchange my personal information with the following persons, organizations or parties: Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled. When providing personal information for my spouse and/or dependants, **I confirm** that I am authorized to act on their behalf. **I agree** that a photocopy or electronic copy of this Authorizations & Declarations section is as valid as the original. **I certify** that the information given is true, correct and complete to the best of my knowledge

Date ___ ___ ___ y m d Plan Member's Signature _____

Protecting your personal information The administrator of your group benefit plans is Coughlin $ Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

All information recorded on this form is confidential
MAIL THE COMPLETED FORM AND ORIGINAL RECEIPTS TO THE PLAN ADMINISTRATOR'S OFFICE FOR PROMPT PROCESSING

UNION LABEL

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