TEAMSTERS CANADA RAIL CONFERENCE (CN RAIL)

STATEMENT OF COVERED EXPENSES FOR SUPPLEMENTARY HEALTH BENEFITS

TO BE COMPLETED BY MEMBER:

Staple original itemized receipts for each expense claimed. Return claim to your Benefits Administrator.

MEMBER'S NAME	SOCIAL INSURANCE NUMBER	DATE OF BIRTH Day Month Year	SEX
MEMBER'S ADDRESS NO. AND STREET	CITY	PROVINCE	POSTAL CODE

Are health benefits payable from another group plan? ☐ Yes ☐ No

If 'yes', policy number _____ And name of insuring agency _____

If coordination of benefits no longer applied - termination date _____

If 'yes' and claim is for a dependent child, please indicate spouse's date of birth _____

If child, indicate ☐ Student Date enrolled _____

(Please provide a copy of current school year registration)

	FIRST NAME	SEX	BIRTHDATE D M Y	DATE EXPENSE INCURRED	DRUGS: NAME OR D.I.N. OTHER: TYPE OF EXPENSE	AMOUNT CHARGED
MEMBER						
SPOUSE						
CHILDREN						

I CERTIFY THAT THE ABOVE STATEMENT AND ATTACHEMENTS ARE COMPLETE AND CORRECT. I HEREBY AUTHORIZE THE RELEASE TO CANADIAN BENEFITS, OF ANY INFORMATION REQUESTED IN RESPECT OF THIS CLAIM. CANADIAN BENEFITS MAY USE MY SOCIAL INSURANCE NUMBER, IF PROVIDED ABOVE, FOR ALL CLAIM RELATED PURPOSES.

DATE: _____ MONTH _____ YEAR _____ MEMBER'S SIGNATURE: _____

Certified by Local Officer _____

Signature

Administrator:

Canadian Benefits CONSULTING GROUP

(Please submit claims to:)

2300 Yonge Street , Suite 3000, Toronto, Ontario M4P 1E4

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