

## SHEET METAL WORKERS LOCAL UNION 30 BENEFIT PLAN HEALTH CARE SPENDING ACCOUNT CLAIM SUBMISSION FORM

This form should be used when claiming reimbursement under your Health Care Spending Account for eligible expenses which are not covered (or not covered in full) by your Health or Dental Plan.

Green Shield I.D. #	Alternate I.D. #			Date of Birth / /		
Surname	First Name			YY	MM DD	
Mailing Address						
				Telephone No. ( )		
City Province	Province		e			
Do you, or your spouse have any other group insurance coverage that may include these services as benefits? Yes \( \sqrt{No} \sqrt{\sqrt{No}} \sqrt{\sqrt{No}} \sqrt{\sqrt{No}} \sqrt{\sqrt{No}} \sqrt{\sqrt{No}}						
If yes, please provide Insurance Company name						
Be sure you have first submitted these claims to any provincial health insurance, or any private health care plan you may have (including another Green Shield plan, spousal plan, etc.)						
I want my eligible expenses paid from my Sheet Metal Workers Local Union 30 Benefit Plan <b>first</b> and any unpaid portions of my eligible expenses paid From my HCSA.						
☐ I want all my eligible expenses paid directly from my HCSA.						
NOTE: If no box has been checked, we will pay claims according to Box 1.						
HEALTH CARE EXPENSES (Please include receipts, prescriptions, etc.)						
Description of Expense	Date of Expense	Name		Dependent #	Amount	
Total Amount Claimed \$						
by signing this craim form and/or submitting actual receipts, I agree that the mormation provided on this form is complete and accurate Lunderstand that the information provided by me to Green regulation			regulations o		Canada and the rules and rize Green Shield to charge nding Account.	
I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.  Signature			Signature of	re of Plan Member		
Mail this form and enclosures to: For inquiries contact:						
Sheet Metal Workers Ecour Official Sty Benefit Figure			uistration Office  -800-263-3564 or 905-946-9700			
Attention: Health Care Spending Account  Toll Free 1-800-263  45 McIntosh Drive, Markham, ON L3R 8C7  Email: info@lu30plan						
By signing below, I hereby certify that the information provided is true to the best of my knowledge, and consent to the collection, maintenance, use and disclosure of my personal information as described in the Privacy Statement below. I acknowledge that providing my consent will allow access to the information required to assess my benefit eligibility and entitlement, and that refusing to consent may result in delay or denial of my request and/or benefit. This consent may be revoked by me at any time by sending written instructions to the Plans' Administration Office.  I consent to the collection, use and disclosure of my personal informationYESNONO						

Privacy Statement: I authorize the Sheet Metal Workers Local 30 Benefit Plan and the Sheet Metal Workers Local 30 Pension Plan (together called "the Plans"), their administrator Employee Benefit Plan Services Limited, and providers working with the Plans or administrator to collect, maintain, use and disclose my personal information that is necessary for the administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plans may collect, maintain, use and disclose my personal information with relevant persons or organizations (employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal counsel, other plans or unions, pharmacies, regulators, re-insurers) in order to manage the Plans and entitlement to the benefits of the Plans, and may include information such as financial, health or benefits related information. Questions related to the Privacy Statement should be directed to the Privacy Officer.