Manulife Financial

SUPPLEMENTARY HEALTH EXPENSE CLAIM
UNION GROUP

- ADMINISTRATIVE USE ONLY -

Policy effective date _____ (day / mo. / yr.)

Insured Member's effective date _____ (day / mo. / yr.)

In Benefit: ☑ YES ☒ NO

Year	1 Jan	2 Feb	3 Mar	4 Apr	5 May	6 Jun	7 Jul	8 Aug	9 Sept	10 Oct	11 Nov	12 Dec

Signature verifying eligibility _____

PLEASE PRINT

1. Name of Union _____ Local _____
2. Name of Employer _____
3. Insured Member _____ (First name) _____ (Surname) Group No. _____
4. Address _____ (Street)
   _____ (City) _____ (Province) [ ][ ][ ][ ][ ][ ] (Postal Code)
5. SIN [ ][ ][ ][ ][ ][ ][ ][ ][ ]
6. Are health benefits payable from any other company or source for these expenses? ☐ NO ☐ YES
   If "YES", please provide name of company or source _____

Below, list all expenses for both yourself and your dependents. **Attach all receipts.**

Receipt Date	CLAIMANT INFORMATION				Name of Drug or Description of Item	Prescription No.	Nature of Illness	Charge
	Claimant's First Name	Relationship to Insured Member	Date of Birth	Working Full Time?				

TOTAL

I authorize Manulife Financial and/or its authorized representative to collect, use and disclose personal information concerning me and/or my dependant(s) (where applicable) for the purpose of determining eligibility for Manulife Financial products and services; underwriting and administration of coverage; the adjudication and payment of claims and other relevant purposes, all of which are described in more detail in Manulife Financial's Privacy Policy and Privacy Information Package, available at www.manulife.ca or by request.

I hereby certify that each of the above listed drugs or expenses was purchased or incurred in connection with the medical treatment of the above named individuals. I authorize the use of my Social Insurance Number (SIN) for claim identification purposes only. I authorize physicians, hospitals and others to release full information with respect to this claim.

INSURED MEMBER'S SIGNATURE _____ DATE _____