COUGHLIN
employee benefits specialists
Coughlin & Associates Ltd. is a People Corporation company

MEDICAL EXPENSE CLAIM FORM

INSTRUCTIONS

1. Complete this form for **all** medical expenses and services. For dental expenses, complete the *Dental Expense Claim Form.*
2. Print clearly and ensure that all required sections are completed. An incomplete form may result in a delay in processing.
3. Attach the **original** receipt for each expense claimed and retain a copy for your records.
4. Sign and date the form and return to Coughlin & Associates Ltd. for processing.

Mailing address
PO Box 764
Winnipeg, MB R3C 2L4
E-mail:
winnclaims@coughlin.ca

Tel: 204-942-4438
1-888-204-1234
Fax: 204-942-2741
www.coughlin.ca

1. PLAN MEMBER INFORMATION

Plan sponsor/Group name			Member ID/PIN	
Insulators Local Union 119 (Policy# 150601)				
Member last name	Member first name	Member middle initial	Sex ☐ Male ☐ Female	Date of birth (yyyy/mm/dd)
Mailing address		City	Province	Postal code
Email address	Primary telephone	Secondary telephone	Language of correspondence	☐ English ☐ French

2. COORDINATION OF BENEFITS How to submit a claim when there are two plans

- Send your claims to your own plan first. When you receive your explanation of benefits, send it along with copies of your receipts to your spouse's plan to claim any unpaid amount.
- Send your spouse's claims to their plan first, then send a copy of their explanation of benefits and receipts to your plan.
- Send your children's claims first to the plan of the parent whose birthday (month and day) occurs first in the calendar year.

Are any of the expenses associated with a work related incident AND eligible for workers' compensation benefits? ☐ Yes ☐ No
If yes, submit these expenses to your provincial workers' compensation board.

Are any health benefits or services provided under any other group insurance or health plan or government plan? ☐ Yes ☐ No
If yes, who is the member of this other plan? Name _____ Date of birth (yyyy/mm/dd)_____ Relationship to plan member _____

If your other benefit plan is with Coughlin, do you want us to process the claim through both benefit plans? ☐ Yes ☐ No If yes, complete the following:

Plan sponsor/Group name	Last name	First name	Member ID/PIN	Signature
				You must print THEN sign this form

3. CLAIM INFORMATION For equipment and appliance expenses, a written recommendation from the prescribing physician is required, including diagnosis and a copy of the provincial plan statement of payment (if applicable).

Patient last name	Patient first name	Type of expense	Date of birth (yyyy/mm/dd)	Relationship to plan member	Full-time student	Disabled child	Amount claimed
		☐ Drug ☐ Other ☐ Vision			☐ Yes ☐ No	☐ Yes ☐ No	$
		☐ Drug ☐ Other ☐ Vision			☐ Yes ☐ No	☐ Yes ☐ No	$
		☐ Drug ☐ Other ☐ Vision			☐ Yes ☐ No	☐ Yes ☐ No	$
		☐ Drug ☐ Other ☐ Vision			☐ Yes ☐ No	☐ Yes ☐ No	$

4. VISION CARE EXPENSES Complete only if submitting a vision care expense

Is this a new prescription? ☐ Yes ☐ No

Check one (if applicable) ☐ Occupational safety glasses ☐ Prescription sunglasses ☐ As a result of cataract surgery (attach physician's recommendation)

5. HEALTH CARE SPENDING ACCOUNT Complete only if you have this benefit

I confirm that I am eligible for a reimbursement of the indicated expenses under my Health Care Spending Account (HCSA). I understand that I must first submit my claim using the co-ordination of benefits with my spouse's plan, if applicable.

☐ I do not wish to use my HCSA ☐ I wish to use my HCSA to cover the expenses that are not reimbursed under my group insurance plan

6. OTHER INFORMATION

Attach your original receipts to this form and keep photocopies for your files. The original copies will not be returned. Your explanation of benefits and the copies of your receipts are sufficient for coordination of benefit purposes. Claims MUST BE submitted no later than the period defined in your benefit booklet.

7. AUTHORIZATION & DECLARATION

I authorize Coughlin & Associates Ltd. ("Coughlin") to collect, use, maintain and disclose my personal information with the following persons, organizations or parties: health care providers; companies affiliated with Coughlin; financial institutions; government agencies; insurance companies and their reinsurers and/or service providers; employers or former employers; my local union; plan trustees and auditors for the purposes of plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility (as applicable). 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 form is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Member signature	Date (yyyy/mm/dd)
You must print THEN sign this form	

Protecting your personal information: Coughlin recognizes and respects every individual's right to privacy. We are committed to keeping personal information private, confidential, accurate and secure. When personal information is provided to us, we establish a confidential file that is kept in our office, or the office of an organization authorized by us. Personal information is kept in a secure environment. We limit access to personal information in your file to Coughlin staff or persons authorized by Coughlin who require access to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the personal information to administer the plan. You may exercise certain rights of access to the personal information in your file, and where appropriate, to have inaccurate information corrected by sending a written request to Coughlin. For information on our Privacy Policy, visit our website at www.coughlin.ca, or send a written request to our Privacy Officer by mail or by email at privacy@coughlin.ca.