Ironworkers Health & Welfare Trust Fund of Western Canada
Health Spending Account Claim Form

Attach the original receipts for all expenses. Receipts will not be returned, as a copy of the Explanation of Benefits is sent to you and copies of receipts are sufficient for income tax purposes or coordination of benefits with other group plans.

Your claim will be returned to you if the claim form is incomplete.

Member Information Section

Local Union	Certificate Number	Gender			Language Preference	
		☐ Male	☐ Female	☐ Other	☐ English	☐ French

Last Name	First Name	Date of Birth
		Month Day Year

Mailing Address	City	Province	Postal Code

Phone Number	Cell Phone	Email Address

If claim is on behalf of an eligible dependent, please answer the following

Dependent Name	Relationship of Dependent		Gender			Dependent Date of Birth
	☐ Spouse	☐ Child	☐ M	☐ F	☐ O	Month Day Year

If the claim is for a dependent child 18 years of age or older, please indicate: ☐ Full-Time Student ☐ Part-Time Student

School Name Expected Date of Graduation Month Day Year

Claim Details Section

Item Submitted	Name of Supplier	Date of Paid Receipt	Amount Charged
		Month Day Year	
		Month Day Year	
		Month Day Year	
		Month Day Year	
		Month Day Year	

Authorization—Signature Required Below

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Ellement to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the claim and to administer the group benefit plan. I certify that the information given is true, correct, and complete to the best of my knowledge and that each of the above expenses are for medical treatment that I and/or my dependents received. I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the supplier for the entire amount.

Month / Day / Year

Signature of Member **Date Signed**