LEE-POWER & ASSOCIATES INC.

Medical Expense Claim Form

Instructions: Attach all bills and receipts for which claims are being made. Please complete all sections. All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his/her behalf when necessary to confirm eligibility and to mutually manage claims

Mail completed form to: Lee-Power & Associates Inc.
616 Cooper St., Ottawa, ON K1R 5J2
Phone: (613)236-9007 **Fax:** (613)236-0329
E-mail: benefits@lee-power.ca

Please Print

Part 1: Plan Member's Statement

Group Name: Local No. 7 - I.U.B.A.C. Benefit Trust Fund		Group Number: 31702	
Plan Member Name:		Date of Birth:	
Address:	City :	Province:	Postal Code:
Phone Number: Home:	Work:	Certificate Number:	

Part 2: Coordination of Benefits

Are you or any other member of your family entitled to benefits under any other group insurance plan, or Worker's Compensation?

☐ Yes ☐ No

If "Yes", what is the name of the family member insured:	Relationship to plan member:
Name of other insurance company:	Policy Number:
Spouse's date of birth:	Spouse's Certificate Number:

Part 3: Dependent Information (complete only if you are claiming an expense for a dependent)

Patient Name	Relationship	Date of Birth	Full-Time Student?	Employed?

Part 4: Claim Details

Patient Name	Drug Expenses		Other Expenses		
	# of Receipts	Total Charge	Type of Expense	Nature of Illness	Total Charge

If additional space is needed, please attach a separate page

I hereby authorize Lee-Power & Associates and the insurer Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies administrators of government benefits or other benefits programs, or other service providers working with Lee-Power to exchange personal information when necessary for claims adjudication purposes. I authorize the use of my Social Insurance number for tax reporting purposes and as an identification number where it is require in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge

Plan Member's Signature:	Date:

At Lee-Power & Associates we recognize and respect the importance of privacy. Personal information will be used solely for the purposes of assessing your claim and administering your group benefits plan. (Français au verso)