

**MAIL ALL CLAIMS TO: LOCAL 183 TRUST ADMINISTRATION  
1263 WILSON AVENUE, SUITE 205  
NORTH YORK, ONTARIO M3M 3G2**

**CLAIM ENQUIRIES: 416.240.7487**

Please type or print, including all information indicated. Use more than one form if necessary.

|  |  |                                    |                    |   |  |
|--|--|------------------------------------|--------------------|---|--|
| Employer   |  | Employer location (city and prov.) |                    |   |  |
| Member's Name  |  | Policy No.                         | Identification No. | Date of Birth<br>Mo. Day Yr.  |  |
| Member's Address<br>No. and Street City Prov. Postal Code  |  |                                    | Telephone Number   | <input type="checkbox"/> Initial Claim<br><input type="checkbox"/> Subsequent Claim |  |
| Have you (or your dependant) any other coverage which would pay a benefit for this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                    |                    |   |  |
| If "Yes", policy number _____ and name of insuring agency _____  |  |                                    |                    |   |  |
| If "Yes" and claim is for a dependent child, please indicate spouse's date of birth _____  |  |                                    |                    |   |  |
| If child, indicate <input type="checkbox"/> student <input type="checkbox"/> handicapped   |  |                                    |                    |   |  |

|                    | FIRST NAME | SEX | DATE OF BIRTH |   |   | DATE EXPENSE INCURRED | NAME AND ADDRESS OF SUPPLIER OF PHARMACY | DRUGS: NAME OR D.I.N.<br>OTHER: TYPE OF EXPENSE | AMOUNT CHARGED |
|--------------------|------------|-----|---------------|---|---|-----------------------|--|---|----------------|
|                    |            |     | D             | M | Y |                       |  |   |                |
| MEMBER             |            |     |               |   |   |                       |  |   |                |
|                    |            |     |               |   |   |                       |  |   |                |
|                    |            |     |               |   |   |                       |  |   |                |
|                    |            |     |               |   |   |                       |  |   |                |
| SPOUSE             |            |     |               |   |   |                       |  |   |                |
|                    |            |     |               |   |   |                       |  |   |                |
|                    |            |     |               |   |   |                       |  |   |                |
| UNMARRIED CHILDREN |            |     |               |   |   |                       |  |   |                |
|                    |            |     |               |   |   |                       |  |   |                |
|                    |            |     |               |   |   |                       |  |   |                |
|                    |            |     |               |   |   |                       |  |   |                |

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to [www.greatwestlife.com](http://www.greatwestlife.com).

I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Plan Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

**YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL**