SASKATCHEWAN PIPING INDUSTRY HEALTH & WELFARE

MEDICAL CLAIM FORM

Agent/ Administrator
Global Benefits
88 St. Regis Crescent South, Toronto, Ontario M3J 1Y8
Telephone: (416) 635-6000 Fax: (416) 635-6464

Members Name First	Middle	Last	Social Insurance Number

Address: Number/Street/Apt. Number	City	Province	Postal Code

Date Member Insured (Day / Month / Year)	Sex	Date of Birth (Day / Month / Year)	Date Dependent Insured (Day / Month / Year)	
/ /	☐ Male ☐ Female	/ /	/ /	☐ Initial Claim ☐ Subsequent

Claim for
☐ Member ☐ Dependent

If claim is for a Dependent Child please indicate Spouse's date of birth

Administrative use only:

Policy Effective Date (Day / Month / Year)	Insured Member's Effective Date (Day / Month / Year)	In Benefit	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
/ /	/ /	✔ Yes ✖ No													

Signature

Date (Day / Month / Year) / /

	FIRST NAME	SEX	DATE OF BIRTH Day	Month	Year	DATE EXPENSE INCURRED DAY/MONTH/YEAR	NAME AND ADDRESS OF SUPPLIER OR PHARMACY	DRUGS: NAME OR D.I.N. OTHER: TYPE OF EXPENSE	AMOUNT CHARGED
MEMBER									
SPOUSE									
UNMARRIED CHILDREN									

Have you any other coverage which would pay a benefit for this claim? Yes ❑ No ❑

I authorize Global Benefits to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Global Benefits will be kept confidential and, where necessary, Global Benefits will be exchanging my personal information. I authorize the following persons to exchange with Global Benefits or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, or plan administrator, government agency, auditing or independent investigative organization, and financial institution. I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Date / / (Day / Month / Year) Signature of Member _____ Telephone Number ( ) _____