SASKATCHEWAN PIPING INDUSTRY HEALTH & WELFARE

MEDICAL CLAIM FORM

Agent/ Administrator **Global Benefits**
901-191 The West Mall. Toronto On M9C 5K8 • Telephone 416-635-6000 • Toll Free 1-800-663-4500 Fax 416-631-3064

Members Name First	Middle	Last	Social Insurance Number

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

Date Member Insured	Sex	Date of Birth	Date Dependent Insured	
____ / ____ / ____ Day Month Year	☐ Male ☐ Female	____ / ____ / ____ Day Month Year	____ / ____ / ____ Day Month Year	☐ 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	Insured Member's Effective Date	In Benefit	Signature	Date
____ / ____ / ____ Day Month Year	____ / ____ / ____ Day Month Year	✔ Yes ✖ No		____ / ____ / ____ Day Month Year

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

	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 ( ) _____