Saskatchewan Piping Industry Health & Welfare Trust Fund

Health Care Spending Account Claim Form

Agent/Administrator
Global Benefits
191 The West Mall Suite 901 Etobicoke, On M9C 5K8
Phone: 416-635-6000 • Toll Free: 1 800-810-2086 • Fax: 416-635-6464 • saskpipingbenefits@globalben.com

Policy 6801HCSA

Members Name First	Middle	Last	Social Insurance Number

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

Date Member Insured *dd/mm/yyyy*	Date of Birth *dd/mm/yyyy*	Date Dependent Insured *dd/mm/yyyy*	☐ Initial Claim ☐ Subsequent

Sex	Claim for	If claim is for a Dependent Child, please indicate Spouse's date of birth
☐ Male ☐ Female	☐ Member ☐ Dependent	

	First Name	Sex	Date of Birth Day	Month	Year	Date Expense Incurred Day/Month/Year	Name and Address of Supplier	• Drugs: Name or D.I.N. • Other: Type of Expense	Amount Charged
Member									
Spouse									
Dependents									

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 _____ Signature of Member _____ Telephone Number (*include area code)* _____

Send all correspondence, this claim form, etc., to the Administrator:

Global Benefits – Claims Department
191 The West Mall Suite 901 Etobicoke, Ontario
M9C 5K8

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