Alberta Carpenters & Allied Workers **TRUST FUNDS**

Mail completed form to:
Alberta Carpenters & Allied Workers Trust Funds
Suite 201, 15210 - 123 Avenue
Edmonton, AB, Canada T5V 0A3

Phone: 780-477-9131, Option #1
Toll Free: 1-800-588-1037, Option #1
www.acawtrustfunds.ca

Health & Wellness Plan • CLAIM FORM • *For Prescription Drugs, Vision Care and Supplementary Medical*

INSTRUCTIONS: Attach bills and receipts for all expenses. **Please don't forget to sign/ date this claim form.**

NOTE: Submitted receipts are part of our records and will not be returned. Please retain your Explanation of Benefits for your Income Tax purposes.

IMPORTANT: Answer all questions. This claim will be returned to you if it's **incomplete**. You must sign where indicated. **Unsigned or improperly signed forms will be returned**.

MEMBERS STATEMENT *Payment and or payment details will be sent to the address below.* (Please Print)

Name of ACAW Member _____ Union ID or SIN _____ Date of Birth MM / DD / YYYY _____

Address (Street / PO Box) _____ City _____ Province _____ Postal Code _____

COORDINATION OF BENEFITS (Please Print)

Are you or any other member of your family entitled to benefits under any other plan? ☐ Yes ☐ No *If "Yes" list their name and your relationship below.*

Name (Relationship: ☐ Spouse ☐ Child) _____ Date of Birth MM / DD / YYYY _____

Name of the Other Insurance Company _____ Policy Number _____

Dependent Children must be claimed under the Spouse with the earlier date of birth.

Is your spouse also a member of the ACAW Health & Wellness Plan? ☐ Yes ☐ No ***Copies of receipts and explanation of benefits from other carrier required for benefit coordination.***

1. DEPENDENT INFORMATION *List all dependents for whom you are submitting expenses.* (Please Print)

If claiming for your **spouse** or **dependent child**, complete the section below. *If claiming for self only go to Section 2 "Claim Details".* **NOTE:** Proof of school enrolment or disability is required.

Name	Relationship	Date of Birth (MM / DD / YYYY)	If dependent child is over 18 years of age: Is child a full-time student?	Does child have a disability?
	☐ Spouse ☐ Dependent		☐ Yes ☐ No	☐ Yes ☐ No
	☐ Spouse ☐ Dependent		☐ Yes ☐ No	☐ Yes ☐ No
	☐ Spouse ☐ Dependent		☐ Yes ☐ No	☐ Yes ☐ No

2. CLAIM DETAILS *Please keep a copy of this form, receipts and any other relevant documentation for your records.* (Please Print)

Name	Relationship	Total # of Receipts	Total Charge ($)
	☐ Member ☐ Spouse ☐ Dependent		
	☐ Member ☐ Spouse ☐ Dependent		
	☐ Member ☐ Spouse ☐ Dependent		
	☐ Member ☐ Spouse ☐ Dependent		
	☐ Member ☐ Spouse ☐ Dependent		

NOTE: If additional space is needed complete and attach another claim form (additional forms are available at **www.acawtrustfunds.ca**).

DIRECT TO SERVICE PROVIDER PAYMENT OTHER THAN DENTAL*

Use this area to assign direct payment to:
Pharmacy, Ambulance and/or Hospital Room Charges ONLY.

The member is responsible for payment to the service provider in the event the claim is denied or if Plan benefits have been exceeded.

Please make payment to:

Name of Service Provider _____

Address _____

City _____ Province _____ Postal Code _____

***NOTE:** For dental claims, please have your dentist complete the reverse side of this form, or they can use a standard dental claim form.

I certify the above statements are true and complete and hereby authorize my insurance company, prepayment organization, employer, hospital or dentist to release all information with respect to myself or my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services.

FOR PLAN USE ONLY

→ _____ → _____

Signature of ACAW Member Date MM / DD / YYYY

• DENTAL CLAIM FORM •

ACAW Health & Wellness Plan

PATIENT

DENTIST ADDRESS

TELEPHONE

UNIQUE ID

FOR DENTIST USE *Additional information, diagnosis, procedures, or special consideration.*

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment.

I acknowledge that the total fee of $ _____ is accurate and has been charged to me for services rendered.

I authorize release of the information contained in this claim form to my insuring company plan administrator.

→ _____

Signature of Patient (Parent / Guardian)

☐ Office Verification: _____

MM / DD / YYYY Date of Service	Procedure Code	Int'l Tooth Code	Tooth Surfaces	Dentist's Fee ($)	Laboratory Charges ($)	Total Charges ($)

Total Submitted Fee _____

This is an accurate statement of services performed and fees charged, E & OE.

→ _____ Signature of Dentist

→ _____ Date MM / DD / YYYY

I hereby assign benefits from this claim (and authorize payment) directly to the above named dentist.

→ _____ Signature of ACAW Member

→ _____ Date MM / DD / YYYY

If denture, crown or bridge, is this initial placement? ☐ Yes ☐ No

If no, give date of prior placement and reason for replacement: _____

NOTE: X-rays are required for assessment of benefit payment for predeterminations.

FOR PLAN USE ONLY

Covered Amount ($)	%	Payment ($)

Plan Allowance .....

Co-Payment Amount .....

Deductible .....

Total Payment .....

BENEFIT BREAKDOWN

Basic .....

Major .....

Orthodontics .....

Processed By: _____

Date: _____

This form was last updated in March 2017.