# ACAW TRUST FUNDS

Mail completed form to:
**ACAW Health & Wellness Plan**
Suite 101, 15315 - 123 Avenue
Edmonton, AB, Canada T5V 1S6

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

**NOTE:** Submitted original 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)

Full 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.*

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

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

Name of the Other Insurance Company _____ Policy Number _____

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 of Spouse and/or Dependent | 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 of Member, Spouse and/or Dependent | 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 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.

→ _____ → _____

Signature of ACAW Member Date MM / DD / YYYY

**FOR PLAN USE ONLY**

Last Updated April, 2023