BOILERMAKERS' NATIONAL HEALTH PLAN (CANADA)
IRISH WORKERS
HEALTH CARE SPENDING ACCOUNT CLAIM FORM

1. Member's name ______________________________ Date of Birth ____/____/____ (Day Mo Year)

2. Address ____

   ____

3. If you are making a claim for your Spouse or Dependant, please provide the following information:

Full Name of Spouse/Dependant	Spouse/ Dependant's Date of Birth	Relationship to Member
______________	____/____/____ (Day Mo Year)	______________
______________	____/____/____ (Day Mo Year)	______________
______________	____/____/____ (Day Mo Year)	______________
______________	____/____/____ (Day Mo Year)	______________

4. All Member and Dependant expenses should be listed here. **Attach receipts**.

MEMBER'S CLAIM

Receipt date Day/Mo/Yr	Description of expense, i.e Drug/Vision Care/Dental etc.	Charge
	Total	

SPOUSE/DEPENDANT'S CLAIM

Receipt date Day/Mo/Yr	Spouse/Dependant's name	Description of expense, i.e Drug/Vision Care/Dental etc.	Charge
		Total	

I certify that the information in this form is true and complete to the best of my knowledge.

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Signature of Member   Date

If you wish to have your payments direct deposited to your Canadian Bank Account, please complete a Health Benefits – Direct Deposit and E-Notification Request form. This form is available on our website at www.boilermakersbenefits.ca.

Member to submit completed claim form and receipts to: **Boilermakers' National Benefit Funds (Canada)**
Administration Office
45 McIntosh Drive
Markham, Ontario, L3R 8C7
Or by Email: dental@boilermakersbenefits.ca

Privacy Statement: The Boilermakers' National Health Plan (Canada), the Boilermakers' National Pension Plan (Canada) (together called "the Plans"), their administrator Employee Benefit Plan Services Limited, and providers working with the Plans or administrator will collect, maintain, use and disclose only the information that is necessary for the administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plans may collect, maintain, use and disclose personal information with relevant persons or organizations (employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal counsel, other plans or unions, pharmacies, regulators, re-insurers) in order to manage the Plans and entitlement to the benefits of the Plans, and may include information such as financial, health or benefits related information. Questions related to the Privacy Statement should be directed to the Privacy Officer.