GROUP LEGAL CLAIM FORM
THE LABOURERS' INTERNATIONAL UNION OF NORTH AMERICA
LOCAL 1059

Group Legal Department
(416) 635-6000

PLAN MEMBER'S INFORMATION

Plan Member's Name: ______________________ Social Insurance Number: ______________

Address: ____

City: ______________ Province: ______________ Postal Code: ______________

Phone Number: (____) ______________ Email: ______________
area code

Claim for: ☐ Plan Member ☐ Dependent ☐ Both

Dependent's Name: ______________________ Relationship: ______________

Family matter claims for the Dependent Spouse (complete if applicable)

Spouse's Address: ____

City: ______________ Province: ______________ Postal Code: ______________

Phone Number: (____) ______________ Email: ______________
area code

Payment will be issued to the Spouse or the Lawyer as requested below.

SERVICE PROVIDER INFORMATION

Service Provider's Name: ____

Phone Number: (____) ______________ Date(s) of service: ______________
area code (mm/dd/yy)

Description of the service(s) provided:

____

____

Matter is: ☐ Completed ☐ Continuing

Legal fees billed: $______________________ (excluding disbursements and taxes)

The Group Legal Benefit Plan will only be responsible for the payment of legal services set out in the current schedule of benefits up to the maximum amount indicated.

Payment to be issued to: ☐ Plan Member ☐ Dependent Spouse (family matters only) ☐ Service Provider

THIS FORM MUST BE ACCOMPANIED BY AN ITEMIZED STATEMENT OF ACCOUNT ON LEGAL LETTERHEAD SETTING OUT THE DATES OF SERVICE, DESCRIPTION OF THE SERVICES PROVIDED AND INDICATE THE LEGAL FEE BILLED SEPARATE FROM DISBURSEMENTS AND TAXES. HIGHWAY TRAFFIC ACT CLAIMS MUST BE SUBMITTED WITH A COPY OF THE TRAFFIC TICKET OR A NOTICE OF TRIAL.

Plan Member's Signature: ______________________ Date: ______________
(mm/dd/yy)

I acknowledge having the described services provided by the aforementioned service provider and hereby waive the Solicitor Client privilege in respect to documentation required to be released to adjudicate and process this claim for benefit.

Mail claim to:

Global Benefits
The Defenders Group
Group Legal Department
88 St. Regis Crescent South
Toronto, ON M3J 1Y8

All shaded areas and the client waiver on the reverse side of the claim form must be completed.

REAL ESTATE AFFIDAVITS

The following section(s) must be completed for the purchase or sale of the Plan Member's principal family residence. Purchase or sale of an income producing or commercial property is not covered under the Plan.

PURCHASE OF FAMILY DWELLING

I ______________________________ solemnly swear that the property which was
Plan Member's Name
purchased (excluding vacation property) shall be used as a principal residence for myself and my family, effective the date of closing.

Address of Property: ______________________________

City: ______________ Province: ______________ Postal Code: ______________

Plan Member's Signature: ______________________ Date: ______________
(mm/dd/yy)

SALE OF FAMILY DWELLING

I ______________________________ solemnly swear that the property which was sold
Plan Member's Name
(excluding vacation property) was a principal residence for myself and my family immediately prior to its sale.

Address of Property: ______________________________

City: ______________ Province: ______________ Postal Code: ______________

Plan Member's Signature: ______________________ Date: ______________
(mm/dd/yy)

CLIENT WAIVER

This section must be completed.

I authorize Global Benefits to collect and exchange personal information about me and/or my dependents to process this claim and administer my group legal benefit 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 legal counsel and/or agent, the plan administrator, government agency, auditing or independent investigative organization. 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.

Plan Member's Signature: ______________________ Date: ______________
(mm/dd/yy)

Phone Number: (______) ______________________
area code