



LiUNA Local 1059 Benefit Trust

W.A. Health Inc. 149 Main St E, Hamilton ON L8N 1G4 • (289) 768-3621

Medical Claim Form

Members First Name	Middle	Last	Certificate No.
Address: Number/Street/Apt. Number		City	Province
Postal Code	Member's Date of Birth dd/mm/yyyy		Sex
<input type="checkbox"/> Female <input type="checkbox"/> Male		Claim for	
<input type="checkbox"/> Member <input type="checkbox"/> Dependent			

Have you or your dependent on any other coverage which would pay a benefit for this claim? Yes No

If yes, name of Employer and Insurance Co. _____

If yes, please indicate spouse's date of birth dd/mm/yyyy _____

I authorize W.A. Health 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 W.A. Health will be kept confidential and, where necessary, W.A. Health will be exchanging my personal information. I authorize the following persons to exchange with W.A. Health 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 valid as the original.

Date Day Month Year

Signature of Member

Telephone Number (include area code)

SEND ALL CORRESPONDENCE,
THIS CLAIM FORM, ETC.
TO CLAIMSECURE INC.

CLAIMSECURE INC.
P.O. BOX 6500, STATION A
SUDBURY, ONTARIO, P3A 5N5
TELEPHONE: (888)513-4464
EMAIL: claimsubmission@claimsecure.com