SEAFARERS' MEDICAL PLAN

200 – 3131 Pitfield Blvd.
Saint-Laurent, QC H4S 1N3
TEL.: (514) 931-7859 Ext 227

This form is to be completed if you are claiming for hospital, medical, dental care and vision care benefits.

Attach your official bills or receipts (or Standard Dental Claim form).

STATEMENT BY THE SEAFARER

NAME OF SEAFARER		UNION NO.	DATE OF BIRTH DAY / MONTH / YEAR
SOCIAL INSURANCE NO.	MEDICARE NO.	ADDRESS	APT.
PHONE NO. ( )		CITY	PROVINCE / POSTAL CODE
NAME OF EMPLOYER COMPANY		NAME OF LAST SHIP	RATING
NAME OF SPOUSE		DATE OF BIRTH DAY / MONTH / YEAR	IS THE SEAFARER'S SPOUSE ALSO A SEAFARER? IF SO, STATE UNION NO.

NAMES OF DEPENDENT CHILDREN UNDER THE AGE OF 18, OR PERMANENTLY DISABLED CHILDREN		DATE OF BIRTH DAY	MONTH	YEAR
INDICATE ALL YOUR DEPENDENT CHILDREN EVEN IF THIS CLAIM DOES NOT CONCERN THEM.	1.			
	2.			
	3.			
	4.			
	5.			

INDICATE BELOW WHAT YOU ARE CLAIMING FOR AND FOR WHOM:

TYPE OF CLAIM (Example: eyeglasses)	NAME (Example: Annie, daughter)

If any of the claims indicated above is for the Seafarer's spouse, is he/she covered by any other insurance for this type of claim?

☐ YES NO ☐ Type of claim: _____

☐ YES NO ☐ Type of claim: _____

☐ YES NO ☐ Type of claim: _____

If "yes" the claim must first be submitted to the other insurance plan. The Seafarers' Medical Plan may cover any unpaid balance upon receipt of proof of the amount paid by the other insurance plan.

I HEREBY CERTIFY THAT ALL THE ABOVE INFORMATION IS TRUE AND THAT THE DOCUMENTS SUBMITTED HEREWITH ARE AUTHENTIC. SHOULD ANY OF THE SAME DOCUMENTS SUBMITTED ON MY BEHALF BE FOUND TO HAVE BEEN FALSIFIED, I WILL BE LIABLE TO SUSPENSION OF FURTHER BENEFITS.

_____ _____

SIGNATURE OF SEAFARER OR SPOUSE DATE