

**LABORERS' HEALTH & WELFARE TRUST FUND OF WESTERN CANADA
FLEX WORKS HEALTH CARE EXPENSE ACCOUNT CLAIM FORM**

USE THIS FORM to submit claims to be paid from your Health Care Expense Account. Refer to your FlexWorks Enrollment Booklet for a list of expenses which qualify. **DO NOT USE THIS FORM FOR NORMAL CLAIMS.**

Member Information		Local Union No		COMPLETE ALL SECTIONS PLEASE PRINT					
Name (Last)	(First)	Sex (please circle)		Date of Birth					
		M	F	M	D	Y			
Address (Street)		Social Insurance Number							
City	Prov	Postal Code			Telephone Number				

IF CLAIM IS ON BEHALF OF AN ELIGIBLE DEPENDENT, PLEASE ANSWER THE FOLLOWING

Dependent Name	STATUS		Sex (please circle)		Date of Birth			
	<input type="checkbox"/> SPOUSE		M	F	M	D	Y	
		<input type="checkbox"/> CHILD		M	F			
If the Claim is for a dependent child 18 years of age or older, please indicate:						Expected Date of Graduation		
School Name _____						M D Y		

LIST AND ATTACH ALL PAID RECEIPTS OR INVOICES FOR THIS CLAIMANT

ITEM SUBMITTED	NAME OF SUPPLIER	DATE OF PAID RECEIPT	AMOUNT CHARGED

I certify that the expenses submitted were incurred by myself or one of my dependents. I authorize release of the information contained in this claim form to the Plan Administrator or Consultant for purposes of settlement of this claim.

Signature _____

Date _____

Please return to:

Phone (780) 453-2303

Funds Administrative Service Inc.
9th floor, 9707 - 110 Street
Edmonton, AB T5K 3T4

Toll Free 1-800-661-7369