



# CASUAL UNIT Dental Claim Form

Cheque # \_\_\_\_\_  
Cheque date \_\_\_\_\_

## SECTION 1 – CASUAL MEMBER INFORMATION

PERSONNEL NUMBER	EMAIL ADDRESS	
SURNAME	FIRST NAME	PHONE NUMBER
ADDRESS	SOCIAL INSURANCE NUMBER	
CITY	PROVINCE	POSTAL CODE

## SECTION 2 - ELIGIBILITY

I have been actively employed in the USW Casual Unit for 12 months prior to the date I submit my claim. YES                      NO

I worked with an appointment of 20% or more, or regularly worked 7.25 or more hours each week for 4 consecutive months in the previous 12 months. YES                      NO

If Yes, please list the months: \_\_\_\_\_

I worked at least 5 shifts a month for 4 consecutive months in the previous 12 months. YES                      NO

If Yes, please list the months: \_\_\_\_\_

Please attach timesheets or ESS printouts for the relevant periods of employment. ATTACHED

## SECTION 3 – MANDATORY DECLARATION

Casual employees with other health benefit coverage from the University of Toronto are not eligible to make a claim.

I am not eligible for coverage based on any other U of T employment or student status, including students health benefits, health care spending accounts or retiree benefit plan. AGREE

DATE	PROFESSIONAL/ SUPPLIER'S NAME and Provider Number (if available)	DATE OF CLAIM			TYPE OF EXPENSE	TOTAL AMOUNT CHARGED PER VISIT/ ITEM
		YR	MO	DAY		
<b>TOTAL CLAIMED</b>						

## SECTION 4 - AUTHORIZATION

\_\_\_\_\_

Signature Date

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate.

## SECTION 5 - MAILING INSTRUCTIONS

PLEASE ATTACH ALL ORIGINAL DOCUMENTATION and retain copies for your files as original receipts will not be returned. Send your claim to the corresponding address below.

**USW LOCAL 1998**  
Attention: Financial Secretary  
25 Cecil Street, 3rd Floor, Toronto, ON M5T 1N1  
Contact us at 416-506-9090 or info@usw1998.ca

Meeting date approved: \_\_\_\_\_

