University of Toronto Casual Unit Health Care Benefit Plan Claim Form

MEMBER INFORMATION

Last Name: _____ **First Name:** _____ **Initial:** _____

Social Insurance #: _____ **Date of Birth (DD/MM/YYYY):** ____ / ____ / _____

Address: _____ **Unit #:** _____

City: _____ **Province:** _____ **Postal Code:** _____

Email: _____ **Cell:** _____ **Work #:** _____

CLAIM INFORMATION

Claim Type (Select One):

- ◯ Dental
- ◯ Drug

Do you have other insurance coverage?

- ◯ No
- ◯ Yes
  If yes, insurer name: _____

With this form, please enclose a receipt of payment for drugs purchased or a dental claim form. Please also include time sheets and pay stubs to show that you have met the work criteria for eligibility.

Please mail or email completed form to:

W.A. Health Inc.
149 Main St. E.
Hamilton, ON L8N 1G4

Email: claims@wahealth.ca
Tel: 289-768-3621
Fax: 289-768-3620
Toll Free: 1 -877-207-8234

Member Signature **Date (DD/MM/YYYY)**