

SEAFARERS' MEDICAL PLAN

1333 ST. JACQUES - 2nd FLOOR
 MONTREAL QC H3C 4K2
 TEL.: (514) 931-7859
 FAX: (514) 931-3667



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		IS THE SEAFARER'S SPOUSE ALSO A SEAFARER? IF SO, STATE UNION NO.	
		DAY	MONTH	YEAR	
NAMES OF DEPENDENT CHILDREN UNDER THE AGE OF 18, OR PERMANENTLY DISABLED CHILDREN				DATE OF BIRTH	
				DAY	MONTH
1.					
2.					
3.					
4.					
5.					

INDICATE ALL YOUR DEPENDENT CHILDREN EVEN IF THIS CLAIM DOES NOT CONCERN THEM.

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 _____