UNIFOR LOCAL 3005 RHTF

1376 Grant Avenue, Winnipeg Mb. R3M 3Y4
Plan Administrator: AJ McAulay (204) 612-2775
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NAME OF RETIREE_________________________________ Date Sent________________

ADDRESS____

List all receipts and cost of each item and indicate type of claim as well as name of claimant (who the expense was for).

Drug Claims

Name of Claimant (who is prescription for)	Drug Identification **Number** (DIN #)	Cost of Item

Other expenses (Ambulance, Vision, Orthotics, Podiatrist, Physiotherapy, Cardiac Rehab, Extended, Other)t

Name of Claimant	Type of expense (from list)	Cost of Item

(**For Administration use only**):

Claim	Drugs	Ambulance	Vision	Orthotics	Podiatrist	Physio	Cardiac R	Extended	Other
Self									
Spouse									

Admin.: Date ______________________ Ck Amount____________________ . Ref. # _______________