Member Benefits Trust

EXCESS CONTRIBUTION RESERVES WITHDRAWAL APPLICATION

CLAIM FORM FOR 20___

NAME: _____ ***ADDRESS:*** _____

UBCP # : _____ ***CITY/PROV:*** _____

SOCIAL INSURANCE #: _____ ***POSTAL CODE:*** _____

DATE OF SERVICE	*NAME OF PERSON RECEIVING TREATMENT*	*DOCTOR NAME*	*DESCRIPTION OF EXPENSE*	*NET PAYABLE*
TOTAL EXPENSES:				$

I hereby certify that these expenses were incurred and paid by me and/or my dependents, that they have not been claimed with any other company, and that all the information is correct. I further certify that the dependents for which I have claimed expenses are dependents as defined by the Income Tax Act.

MEMBER SIGNATURE: _____

DATE: _____

Please note: Only expenses with original receipts attached will be accepted for review. Expenses for application of reimbursement must be no older than one calender year.

For Office Use Only:	
Current Balance:	$
Minimum Balance:	$
Available Reserves:	$
Requested Withdrawal:	$
Remaining Balance:	$
Approved by:	
Date Approved:	
Cheque #	