EXTENDED HEALTH CLAIM FORM

Please complete **both sides** of this form in full and attach **photocopies** of all receipts.

Submit the completed claim form and photocopy of receipts to:

1. By mail - Teamsters' National Benefit Plan, 1610 Kebet Way, Port Coquitlam, BC V3C 5W9
2. By email – benefits.pensions@teamstersbenefits.ca **Claim form and receipts must be submitted in PDF format**
3. By fax – 604-552-2653

Claim submission must be supported by receipts confirming payment has been made in full:

- Prescription medications require Official Pharmacare Receipt.
- Itemized statement for physiotherapist, chiropractor, massage therapist, etc.
- Coordination of Benefits must be supported by payment details from the primary insurance carrier.
- **Optical expenses** (must include full details including patient name, date and item purchased).
  -When submitting receipts for glasses or contact lenses they **must be accompanied by the Optician's prescription and proof of purchase which includes method of payment**; for example, credit card or debit receipt.

Please note: Original receipts **must** be retained for 12 months in the event the Plan requests verification. **Receipts submitted to the Plan will no longer be returned.**

Plan Member/Employee Statement

Name _____ **Plan I.D. Number** _____

Address _____

Telephone Number _____ **Email Address** _____

Status of Employment, please check: ☐ Active ☐ Terminated ☐ Laid-off ☐ Leave of Absence

Coordination of Benefits
Please complete this section if you or your spouse/dependents are covered under another plan.

Name of policy holder _____ Date of birth _____

Name of Insurance Provider _____ Policy No. _____

Coverage start date _____ Cancellation date (If Applicable) _____

Has this expense been submitted to other plan? ☐ **YES** ☐ **NO**

I certify that the information I have provided on this form is correct and true. I authorize the Teamsters' National Benefit Plan (the "Plan") to collect, use and disclose my personal information (including my EHB information) to administer a claim for benefits from the Plan and specifically to exchange my personal information with any healthcare provider (including any physician, practitioner, independent medical examiner, hospital and clinic) and with any insurance company or other organization if that exchange is reasonably necessary to administer my claim. This authorization covers personal information the Plan receives from me and from any other person or entity such as a treating healthcare provider or insurance company. I release and hold harmless the Plan (and its employees) from any liability resulting from such collection, use or disclosure. I further confirm that the expenses incurred and claimed are for myself and/or my eligible dependents pursuant to the terms of the Plan.

_____ _____
Member Signature Date

Revised June 2020

EXPENSES LISTED BELOW ARE FOR:

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH

ENTER INFORMATION BELOW FOR ALL EXPENSES YOU ARE CLAIMING

ARE EXPENSES THE RESULT OF A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

DATE OF MOTOR VEHICLE ACCIDENT _____

Type of Expense (For Example, Optical, Physiotherapy, medications etc.)	Patient's Name	Date of Expense/Service	Amount Claimed

CLAIMS FOR ANY CALENDAR YEAR MUST BE SUBMITTED WITHIN 12 MONTHS FROM THE END OF THAT CALENDAR YEAR.

For further information, please contact our office 604-552-2650 or toll free 1-888-478-8111 or visit our website at www.teamstersbenefits.ca