EXTENDED HEALTH CLAIM (EHC) FORM

MAIL: 1610 Kebet Way, Port Coquitlam, BC V3C 5W9
WEBSITE:www.teamstersbenefits.ca
PHONE 604-552-2650 FAX 604-552-2653
EMAIL: benefits.pensions@teamstersbenefits.ca

MEMBER INFORMATION

Name _____ Plan Member I.D. Number _____

Address _____

Telephone Number _____ Email Address _____

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

OTHER BENEFIT COVERAGE

Please complete this section if you or your spouse/dependents are covered under another Benefit/Dental 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 the other plan? Please check: YES ☐ NO ☐ – If yes, payment details from Primary Carrier must be included.

CLAIM INFORMATION

Enter the first name and birthdate of individuals for whom you are making a claim. Provide the total of all expenses submitted for each dependent.

FIRST NAME	BIRTHDATE (DD/MM/YEAR)	TOTAL PAID EXPENSES
	GRAND TOTAL	**$ 0.00**

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

To avoid delay in processing your claim, submission must be supported by receipts confirming payment has been made in full by way of credit card, debit card or e-transfer only (NO CASH). Claims submitted through email must be in PDF Format.

- Prescription medications require Official Pharmacare Receipt.
- Itemized statement for physiotherapist, chiropractor, massage therapist, etc.
- Optical expenses must include full details including patient name, date and item purchased as well as the Optician's prescription.

Please retain copies of your receipts as receipts submitted the Plan are no longer returned.

I ceritfy all expenses claimed have been paid for as indicated on this form. 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. Should there be an overpayment I authorize recovery from any amount payable to me under my benefit plan. I understand my claim may be chosen for review for auditing purposes.

_____ _____

Signature **Date**

Revised March 2021