



# 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](mailto:benefits.pensions@teamstersbenefits.ca)
3. By fax – 604-552-2653

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](http://www.teamstersbenefits.ca)

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 \_\_\_\_\_ Employer \_\_\_\_\_

Status of Employment, please circle: 1. Active 2. Terminated 3. Laid-off 4. 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) \_\_\_\_\_

***I certify that the information I have provided on this form is correct and true. 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

