# *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 **Email must be submitted in PDF format**
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

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.**

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**Plan Member/Employee Statement**

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

**Address** _____

**Telephone Number** _____ **Email Address** _____

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

Revised October 2019

**EXPENSES LISTED BELOW ARE FOR:**

| NAME | DATE OF BIRTH | NAME | DATE OF BIRTH |
|---|---|---|---|
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**ENTER INFORMATION BELOW FOR ALL EXPENSES YOU ARE CLAIMING**

**ARE EXPENSES THE RESULT OF A MOTOR VEHICLE ACCIDENT? Y / N (Circle)**

**DATE OF MOTOR VEHICLE ACCIDENT** _____

| Type of Expense (For Example, Optical, Physiotherapy, medications etc.) | Patient's Name | Date of Expense/Service | Amount Claimed |
|---|---|---|---|
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**CLAIMS FOR ANY CALENDAR YEAR MUST BE SUBMITTED WITHIN 12 MONTHS FROM THE END OF THAT CALENDAR YEAR.**