Print form

EXTENDED HEALTH CLAIM (EHC) FORM

MEMBER INFORMATION ***Banking Information must be on file with the Plan Office or completed in the Direct Deposit section below***

Name: _____ Plan Member I.D. Number: _____

Current Address: _____Telephone No._____ Email_____

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

OTHER PLAN BENEFIT COVERAGE

Please complete this section if you or your spouse/dependents are covered under another EHC Benefit and/or Dental plan.

Name of Insurance Provider:_____ Name of Policy Holder: _____Policy No._____

Policy Holder Date of Birth: day/month/year _____ Coverage Start Date: _____ Coverage End Date: _____

Has this expense been submitted to the other plan? Please check: YES ☐ NO ☐
If yes, payment details from Primary Carrier must be attached.

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

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 certify 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 overpaid benefit, 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**

1610 Kebet Way, Port Coquitlam, British Columbia V3C 5W9
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Fax 604-552-2653