Extended Health Claim Form

Please send claims to:

PO Box 3249, 3756 First Avenue, Smithers,BC V0J 2N0

Instructions: Attach the bills, original receipts and Dental claim forms for dental,for all expenses and itemize them by providing all the information requested. Note: Drug bills receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization or exp that will accompany our cheque for Income Tax Purposes.

Important: Please answer all questions. This claim may be returned to you if it is incomplete or contains errors.

Please Print

Part 1: Employee's Statement

Group Number	Certificate Number	Employer Company Name	
Employee Name		Phone Number Home: Work:	
Mailing Address			
City	Province	Postal Code	Email Address

Please indicate if this is a new address to be updated in the system: Yes__ __ No__ __

Part 2: Coordination of Benefits

Are you or any other member of your family entitled to benefits under another plan? Yes ___ ___ No___ ___

If "Yes", name of family member insured _____ Relationship to employee_____

Name of insurance company_____ Policy number _____ Coverage: Family _____ Single___ ___

If "Family" coverage is specified, and the patient for this claim is a dependant child, please provide spouse's Date of Birth _____(yy/mm/dd)

Is a treatment required as the result of a motor vehicle accident? Yes _____ No___ ___

Is a claim being made for Worker's Compensation Benefits? Yes _____ No___ ___

Part 3: Claim Details

Patient Name:	Number of Receipts:	Type of Expense(s):	Total Charge:
Total amount submitted for reimbursement:			0.00

If additional space is needed, please attach separate page.

I certify that I and/or my dependents incurred these expenses and that the information given is true, correct and complete to the best of my knowledge and that the attached receipts represent a expense that is medically necessary. I authorize Pacific Employee Benefits, healthcare providers, insurance or reinsurance companies, administrators of benefits programs, other organizatoins and service providers to exchange personal information, as necessary, for the adjudication of the claims I submit and the administration of the benefit program. I understand that the personal information will be kept confidential and secure. I have read and understand this Member consent and Declaration.

Signature of Employee _____ Date _____