



TEAMSTERS' NATIONAL BENEFIT PLAN

EXTENDED HEALTH BENEFIT CLAIM FORM

Complete **BOTH SIDES** of this form and attach all receipts.

Mail the completed form and receipts to:

**Teamsters' National Benefit Plan
1610 Kebet Way
Port Coquitlam, B.C.
V3C 5W9**

For information telephone 604-552-2650

All items being claimed must be supported by receipts indicating that payment has been made.

- (A) Prescription Drugs – Official Pharmacare Receipt showing prescription number, name of patient and date purchased.
- (B) Itemized Statement (for a Physiotherapist, Chiropractor, etc.) showing dates of treatment, type of treatment and name of patient.
- (C) Hospitalization Claim Form, for hospital room charges.
- (D) Ambulance Account, showing name of patient and date of service.
- (E) Optical Expenses – receipt showing name of patient, date and type of service.

EMPLOYEE'S STATEMENT

Name: _____ I.D. Number: _____

Address: _____ Telephone No.: _____

_____ Postal Code: _____

Employer: _____

Please give details of any other plan from which you may receive payment for these expenses.

Name of plan: _____ Policy No.: _____

Insurance Co.: _____ Certificate No.: _____

I certify that the information I have provided on this form is correct and true and that items claimed are for expenses incurred on behalf of myself or my eligible dependents.

Date: _____ Employee's Signature: _____



