



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: Social Ins. No.:

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:

