

Registration No.

EXTENDED HEALTH BENEFITS CLAIM

Policy No. 11264	I.D./Certificate Number	
Member Last Name	First Name	
Member Address	City	Postal Code
Name of Employer or Union Affiliation Victoria Mechanical Industry H&W		

Complete form, attach receipts and forward to:
D.A. Townley & Associates Ltd.
160 - 4400 Dominion St., Burnaby, BC V5G 4G3
Please submit receipts on a regular basis to avoid delay in processing.

PharmaCare Registration No.

LIST EXPENSES BELOW, GROUPED BY INSURED PERSON, IN DATE ORDER

We require original receipts. In case of dual coverage, send Statement Of Payment from prime insurer along with photocopies of original receipts.

***PLEASE NOTE: Receipts will not be returned. Please retain copy if required.**

Name (Employee or Insured Dependent)	Relationship to Employee	Birth Date yr/mo/day	Date of Purchase yr/mo/day	Drug/Service Provided	Prescription DIN	Amount Charged
						\$

Additional space on reverse

NOTE: Birthdate for all dependents (spouse & children) must be given.
If dependent is age 21 or older, indicate school he/she is attending.

School: _____ Full Time Part Time

<p>Are any benefits or services provided under any other insurance or supplementary health plan? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "Yes", indicate:</p> <p>Policy No.: _____ Name of insuring agency: _____</p> <p>Name of Insured: _____ I.D./Certificate Number: _____ Date of Birth (y/m/d): _____</p>

<p>Are any of the above expenses the result of a motor vehicle accident/Workers Compensation claim? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "Yes", please specify and explain:</p>

I understand that D.A. Townley & Associates Ltd. collects personal information to assess eligibility for benefits; to determine and adjudicate benefits, to determine the cost and financially manage these benefits, as well as to meet regulatory or contractual requirements relating to such benefits and related services provided. I authorize the release of the information provided on or attached to this form for claims adjudication purposes and statistical analysis.

*Member Signature: _____ Date: _____