Ironworkers Local 97 Health & Welfare Plan

#101 – 4190 LOUGHEED HIGHWAY, BURNABY, B.C. V5C 6A8
Tel: (604) 299-7482 Fax: (604) 299-8136 Toll-Free: 1-800-663-1356 www.ironbenefits.org

EXTENDED HEALTH BENEFITS CLAIM

FOR OFFICE USE ONLY

Registration No.

70682
Group/Policy No. Social Insurance Number

Member Last Name First Name

Member Address

Name of Employer or Union Affiliation

Forward to:

Ironworkers Local 97 Health & Welfare Plan
101 - 4190 Lougheed Hwy, Burnaby, BC V5C 6A8
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

Are any benefits or services provided under any other insurance or supplementary health plan? ☐ ***YES*** ☐ ***NO***

If "Yes", indicate:

Policy No.: _____ **Name of insuring agency:** _____

Name of Insured: _____ **Social Insurance Number:** _____ **Date of Birth** (y/m/d): _____

Are charges covered by the Provincial Hospital and/or Medicare Plan? ☐ ***YES*** ☐ ***NO***

If "Yes", when did the claim exceed the Plan's maximum? _____

Are any of the above expenses the result of a motor vehicle accident/WCB claim? ☐ ***YES*** ☐ ***NO***

If "Yes", please specify and explain:

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 certify that the above statements are correct and hereby authorize any physician, hospital, employer, union or insurance company to release to D.A. Townley & Associates Ltd. any additional information required in connection with this claim. The information released through this authorization will be used for claims adjudication purposes and statistical analysis.

✱Member Signature: _____ Date: _____

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
						$

Please complete the reverse side of this form IN FULL and send together with original receipts to:

IRONWORKERS LOCAL 97 HEALTH & WELFARE PLAN
101 - 4190 Lougheed Hwy.
Burnaby BC V5C 6A8
Tel: (604) 299-7482
Toll-Free: 1-800-663-1356
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