

Mail to:

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STATEMENT OF EXPENSES FOR HEALTH CARE BENEFITS

TO BE CONSIDERED AN ELIGIBLE EXPENSE, CLAIMS MUST BE RECEIVED WITHIN EIGHTEEN (18) MONTHS FROM THE DATE EXPENSE WAS INCURRED OR THE DATE YOUR PLAN TERMINATED USING THE DATE OF SERVICE OR THE DATE SUPPLIES WERE PURCHASED. YOUR CLAIM FORM MUST BE COMPLETED IN FULL.

Plan Name					Ро	licy Number	Member Certificate		
Insulators Local 110 Benefit Plan				1	10				
Member Name			1	Date of Birth			Email Address		
			_	D	MY				
Mailing Address No. and Street				City				Province	Postal Code
Coordination of Benefits									
Do you have another plan that provides Benefits for you or dependants?						Yes 🗆	No 🗆		
	Name of the Insurance Provider							Policy Number	
If yes, indicate:	Type of Coverage	Health Only □				De	ntal Only 🗆	Both 🗆	
	Policyholder's Name (if applicable):							Date of Birth:	
Patient Information Drug Expe					Drug Exper	ises	ses Other Expenses		
Patient Name		Date of Birth			DIN or Drug Nam		Total Charge	Type Of Expense	Total Charge
		D	М	Y					
Total:							Total:		

PLEASE ATTACH RECEIPTS AND DOCTOR REFERRALS*, IF APPLICABLE. PHOTOCOPIES ARE ACCEPTED.

___ Apply my Health Spending Account, if applicable, to any remaining portion of this claim.

In signing this Statement of Expenses, I certify that the charges for the medical supplies which are listed above and for which the bills are attached were incurred by myself or one of my eligible dependants upon recommendation and approval of the attending physician (if required under the terms of the Plan Text or where applicable) and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my eligible dependants. I declare that my statements in this expense reimbursement request are accurate and true.

On behalf of myself and my eligible dependants, I authorize my group benefit provider, PBAS, and any of its affiliates or re-insurers to exchange the personal information contained on this form or any other benefit related personal information contained in their files now or in the future respecting me or any of my eligible dependants. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as I and my dependants are covered by, or are claiming benefits under the present group contract, or any modification, renewal or reinstatement thereof. I agree that a photocopy or electronic copy of this authorization is as valid as the original.