iuoe LOCAL 115 OPERATING ENGINEERS' BENEFITS PLAN

Extended Health Benefits Claim Form

For Office Use Only
Claim Number:

When accumulated receipts exceed the deductible, complete this form, attach receipts and forward to:

Operating Engineers' Benefits Plan
402-4333 Ledger Avenue
Burnaby, BC V5G 4G9

Phone: 604-299-8341
Toll Free: 1-800-663-9524

Please submit receipts on a regular basis to avoid delay in processing.

Social Insurance Number	Member's Last Name	Member's First Name
- -		
Address: Number and Street		
City	Province	Postal Code	Phone Number - -

Please List Expenses Below, Grouped By Insured Person, In Date Order

Original Receipts are required. (In case of dual coverage, please send Statement of Payment from the primary insurer together with photocopies of the original receipts).

Please note that you have until June 30th of each year to finalize claims for expenses incurred during the previous year.

Name Of Person Incurring Expense	Birth Date (MO/DY/YR)	Service / Purchase Date (MO/DY/YR)	Nature of Illness or Injury	Prescription (DIN) or Receipt Number	Amount Paid

Additional space on reverse

NOTE: Birth Date for all eligible dependents (spouse/children) must be provided.
If dependent is age 21 or older, please indicate the school he/she is attending. School:_____
☐ Full Time ☐ Part Time

Are any benefits or services covered/provided under any other insurance or supplemental health plan? ☐ **YES** ☐ **NO**
If "Yes", please indicate:
Policy No.: _____ **Name of Insuring Agency:** _____
Name of Insured: _____ **Social Insurance Number:** _____ **Birth Date** (MO/DY/YR)**:** _____

Are any of the above expenses the result of a motor vehicle accident and/or WCB claim?
If "Yes", please specify and explain: _____

I authorize the release of the information provided on or attached to this form to be used for claims adjudication purposes and statistical analysis. I certify that I and/or my eligible dependents incurred these expenses. To the best of my knowledge, all information herein is correct.

***Member's Signature:** _____ **Date:** _____

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(Continued From Reverse)

Name Of Person Incurring Expense	**Birth Date** (MO/DY/YR)	**Service / Purchase Date** (MO/DY/YR)	**Nature of Illness or Injury**	**Prescription (DIN) or Receipt Number**	**Amount Paid**

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

OPERATING ENGINEERS' BENEFITS PLAN
402 – 4333 Ledger Avenue
Burnaby, BC V5G 4G9

For **inquiries** or if you need a copy of the **Instructions Sheet** on how to complete this claim form, please contact us:

604-299-8341 or 1-800-663-9524 (Toll Free)
e-mail: ehb@iuoe115.com

(This **form** is also available in **pdf** format from our web site: http://www.iuoe115.org

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