

SUPPLEMENTARY HEALTH EXPENSE

MAIL ALL CLAIM FORMS TO:
 BENEFIT PLAN ADMINISTRATORS (ATLANTIC) LIMITED
 55 Elizabeth Avenue, Suite 202
 St. John's, Newfoundland A1A 1W9

BENEFIT PLAN ADMINISTERED BY:
 BENEFIT PLAN ADMINISTRATORS (ATLANTIC) LIMITED

PLEASE TYPE OR PRINT. INCLUDE ALL INFORMATION INDICATED AND ATTACH ALL RECEIPTS. USE MORE THAN ONE FORM IF NECESSARY.

Company Name						Local No.		
Member's Name				Identification Number		Date of Birth		
						Day Mo. Yr.		
Member's Address						Telephone No.		
No. and Street		City		Province		Postal Code		
						()		
IS THIS A CHANGE OF ADDRESS FROM YOUR LAST CLAIM SUBMISSION: YES() NO (). IF YES, PLEASE ADVISE EFFECTIVE DATE OF CHANGE: <u> DD / MM / YY </u>								
Have you (or your dependent) any other coverage which would pay a benefit for this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No						Are expenses related to an accident <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes", name of Employer and Insurance Co. _____						W.C.B. case <input type="checkbox"/> Yes <input type="checkbox"/> No		
If claim is for a dependent child please indicate spouse's date of birth Day _____ Mo. _____ Yr. _____								
M E M B E R	FIRST NAME	SEX	DATE OF BIRTH			DATE EXPENSE INCURRED	DRUGS: NAME OR D.I.N. OTHER: TYPE OF EXPENSE	AMOUNT CHARGED
			D	M	Y			
S P O U S E								
U N M A R R I E D C H I L D						Is child employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Hours per week _____		

I certify that the above information is true, correct and complete. I authorize Benefit Plan Administrators (Atlantic) Limited ("BPA") to collect and use personal information about me and/or my eligible dependents to process this claim and administer my benefit plan. I am aware BPA will keep my personal information confidential and safeguarded.

I am aware that BPA will only release personal information to my eligible dependents specific to their benefit entitlements. I understand that my personal information (and the personal information of my eligible dependents) may only be shared with health care practitioners, medical facilities, providers of health care/dental services or benefits administration services, provincial health insurance plans, insurance carriers, government agencies, and auditing or independent investigative organizations in order to verify eligibility for my benefit entitlements.

I understand that my social insurance number will be kept in strictest confidence and will only be used for income tax reporting purposes and to match my information with the correct member file. I consent to the collection, use and disclosure of personal information as stated above.

Member's Signature _____

Date _____ DD MM YY