# SUPPLEMENTARY HEALTH EXPENSE

MAIL ALL CLAIM FORMS TO:
BENEFIT PLAN ADMINISTRATORS (ATLANTIC) LIMITED
49-55 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. 904 |
|---|---|
| Member's Name / Identification Number / Date of Birth (Day Mo. Yr.) | |
| Member's Address (No. and Street, City, Province, Postal Code) | Telephone No. ( ) |

Have you (or your dependent) any other coverage which would pay a benefit for this claim? ☐ Yes ☐ No
If "Yes", name of Employer and Insurance Co. _____
If claim is for a dependent child please indicate spouse's date of birth Day_____ Mo_____ Yr_____

Are expenses related to an accident ☐ Yes ☐ No
W.C.B. case ☐ Yes ☐ No

**Remaining Balance assessed through Health Care Spending Account (HCSA) or;** ☐
**Entire claim assessed through the Health Care Spending Account (HCSA)** ☐

| | FIRST NAME | SEX | DATE OF BIRTH D | M | Y | DATE EXPENSE INCURRED | DRUGS: NAME OR D.I.N. OTHER: TYPE OF EXPENSE | AMOUNT CHARGED |
|---|---|---|---|---|---|---|---|---|
| MEMBER | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| SPOUSE | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| UNMARRIED CHILD | | | | | | Is child employed? ☐ Yes ☐ 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

***POSSESSION OF THIS CLAIM FORM DOES NOT CONSTITUTE ELIGIBILITY FOR BENEFITS***