





Mailing Address PO Box 7000 Vancouver BC V6B 4E1

Street Address 4250 Canada Way Burnaby BC

 ${}^*\mathrm{Optional},$ but may result in refusal or delay of claim if not provided.

Me	ember Informatio	n										
Men	nber's ID number			Policy number		Membe	r's company name					
Member's last name			 Member's first name			Employment status Full time Part time Retiree Studen			Daytime phone number (10 digits)			
Member's address/city/province/postal code						Check this box is a new addres						
M ₀	ember Consent 8	2 Declara	ation (This section MUST	Γ he siar	ned hefo	re submittin	a)		is a new a	address	
to d prot purp plan I und con	derstand that the personal in etermine eligibility for this be essional, practitioner, institut poses of my enrolment or cov a sponsor when required or p derstand that the personal in sidered. I understand why the sent and Declaration.	nefit, assess a ion or health b verage under t permitted by la formation will l	and pay cla benefits pro this group p w or pursua be kept col	ims. I hereby acknowledge a vider, government and regula blan, or where required or pe ant to its contractual obligatio nfidential and secure. I under	nd agree tha atory authorit rmitted by la ons under my stand that I r	it the personalies or insurer w. I consent to benefit plan. nay revoke thi	I information may be when needed for th o the disclosure of r is consent at any tin	e exchanged between Pacific e purposes stated above or v ny personal information by P ne and acknowledge that sho	Blue Cros where reas acific Blue	ss and a health sonably necessa Cross to my en o, this claim ma	care ary for the mployer or y not be	
Signature X						ľ				Date (yyyy/mm/	Date (yyyy/mm/dd)	
	claimant is under 18 years of age, t cher Coverage	he member's sig	nature is requ	iired.								
		la a va a de la a vi				ls vour cl	aim the result of	an accident? If yes, attack	h dotails			
Do you or your dependents have other insurance to cover these benefits?						Is your claim the result of an accident? If yes, attach details. Is this a WorkSafe BC (WCB) case?					∐Yes ∐No	
Name of the other insurance company Policy number						, ,				∐ Ye	YesNo	
ID number Name of member with other insurance company					pany	Is this an ICBC, or other auto insurance, case?				Ye	YesNo	
Employment status						Are you seeking damages from a third party?				Ye	Yes No	
	Full time Part time	Retiree	Stude	ent				ext to claims that are rela	ated to ac	cidental or		
Effective date (yyyy-mm-dd) Cancellation date (yyyy-mm-dd)						occupational injuries. If any of these expenses are due to a medical emergency while you were outside of						
	e: If you are claiming for th tocopies of your receipts an			'	ny, include	the provi	•	e, visit CARESnet® to dowr				
Ex	pense Information	on			D . ()							
	First name of claimant (list in dependent and date order)	Birthdate (yyyy-mm-dd)	Dependent number	Type of expense or name of medication (e.g. Hospital, Ambulance, or name of clinic)	hospital admissio	urchase or service or on and discharge dates o-mm-dd)	Amount paid	Provider of service or prescriber of medication	Natur	re of illness or injury*	See above	
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12					+				1		\dashv	

Total claim (optional):

IMPORTANT CLAIMING INFORMATION

Incomplete Extended Health claims may cause delays in processing.

- 1. Read these instructions before submitting this form.
- 2. Ensure you have completed all sections.
- 3. Refer to your Pacific Blue Cross (PBC) ID card for your Policy, ID and dependent numbers.
- 4. To ensure prompt processing of your claim, please:
 - Ensure all supporting documents and original receipts are included (remember to keep photocopies for your records as we do not return receipts).
 - Keep your receipts loose and flat in the envelope (no staples, paper clips or tape)
 - Submit only one of each official receipt (no cashier or Interac receipts)
 - Put all of your health expenses on one form (drugs, paramedical treatments, etc)
 - Mail the signed form, with your receipts, to Pacific Blue Cross at the address indicated on the form. Forms may also be delivered in person to our office.

We encourage you to keep a copy of your Explanation of Benefits statement for income tax purposes. Up to 2 years' worth of statements can also be freely downloaded from CARESnet.

- 5. All claims must be submitted with itemized statements and original, paid-in-full receipts, and must include:
 - Claimant's first and last name
 - Description of item purchased or service rendered
 - Date of each purchase or service
 - Amount charged for each purchase or service
 - Name, address and telephone number of supplier or provider
- 6. Claims must be received in our office before the claiming deadline.
- An Explanation of Benefits (EOB) statement indicating how the claim was assessed will be sent to the member

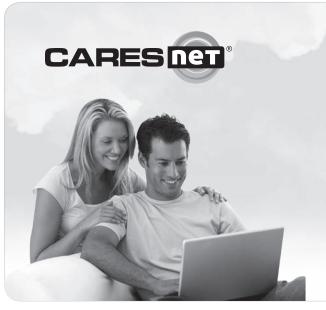
or posted in CARESnet*. Eligible claims will be paid by cheque, attached to the EOB statement, or by direct deposit to your bank account. The EOB statement can be used for income tax purposes or to claim through other coverage. No other statements will be issued. Register for direct deposit, and to receive and view your EOB statements online, by visiting CARESnet*. Refer to CARESnet* for a list of benefits and conditions of eligibility, or refer to your plan booklet. If you do not have a plan booklet, contact your plan administrator.

8. For help completing this form or for more information on your EHC plan, call us at 604 419-2600 or 1 888 275-4672 or visit CARESnet® at www.pac.bluecross.ca

Other Health Benefit Plan Coverage

Photocopies of receipts are acceptable if one the following situations applies:

- 1. If you are claiming expenses for your spouse and your spouse is covered under another health benefit plan, you must submit the claim to your spouse's plan first.
- 2. If both you and your spouse have health benefit coverage, your children must claim under the plan of the parent with the earliest birthday (month and day) in the calendar year. (For example: If your birthday is May 1 and your spouse's is June 5, your children will claim under your plan first).
- 3. If you have submitted your original receipt to your other insurance company, please provide the following:
 - Photocopies of all invoices and paid-in-full receipts
 - The original statement from the other insurance company showing payment or denial of your claim.



Secure 24-hour access to your benefit and claim information

- View a summary of your EHC or dental plan
- Inquire about your claim history
- · Download claim forms
- · Print your own replacement ID cards
- · Enrol for direct deposit and online claims statements
- Get the CARESnet App for your mobile devices

www.pac.bluecross.ca