PACIFIC BLUE CROSS™

Extended Health Care Claim form

• Please read instructions on reverse side before completing form

NAME: _____ DATE OF BIRTH _____ IDENTITY NUMBER _____ POLICY NO. 909800

ADDRESS _____

_____ POSTAL CODE: _____

PHONE _____

MEMBER OF:
- ❒ U F A W U
- ❒ NBBC

- ❒ FISHER
- ❒ FISH PACKER
- ❒ RETIRED
- ❒ STAFF

FISHING YOU HAVE DONE IN THE PAST YEAR:

DATES	GEAR	BOAT	COMPANY

A Type of Expense (Drugs, hospital, ambulance, chiropractor etc.)	B Name of person incurring expense	C Dependent number (00, 01 etc.)	D Dependent's date of birth	E Date of purchase or expense	F Name of doctor prescribing or recommending service	G Amount paid
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						

Is your claim the result of an accident? ❒ Yes ❒ No If yes, attach details.

Is this a Workers' Compensation (WCB) case? ❒ Yes ❒ No Claim #_____

Is this an ICBC or other auto insurance case? ❒ Yes ❒ No

Are you seeking damages from a third party? ❒ Yes ❒ No

Are any of these expenses due to a medical emergency while you were outside of the province where you live? If yes, please see the specific instructions under Out of Province on the back of this form.

Duplicate coverage information:
Do you or any of your dependents have other insurance to cover these benefits?

❒ Yes ❒ No If yes:

_____
Name of the other insurance company

_____
Group number ID number

_____
Name of member with other insurance company

_____
Effective date Cancellation date

If you are claiming for the balance not paid by the other insurance company, include photocopies of your receipts and their payment statement.

Pacific Blue Cross does not return receipts. Please save our Explanation of Benefits for income tax purposes. If you also have coverage with another insurance company make a photocopy of all receipts before sending the originals to PBC. I certify that I and/or my dependents incurred these expenses. All information is true and complete. I consent to the disclosure of this personal information by PBC to UFBF, to other insurance companies, and to other authorized third parties for the purpose of administering my plan, assessing and providing benefit coverage, or when required or permitted by law.

_____
Member's Signature (Date)_____

UNITED FISHERMEN'S BENEFIT FUND

#4 -830 14th Ave, Campbell River, B.C V9W 4H4 Phone: 778 645 0578 Email: Benefits@UFAWU.org

EXTENDED HEALTH BENEFIT • INSTRUCTIONS

- Please ensure that you include your Pacific Blue Cross identity number (not your social insurance number) on the front of this form. Your PBC ID number can be found on your PBC card.
- Please make sure that you sign and date each claim form in the space provided on the first page, bottom right hand side.

WHEN TO FILE A CLAIM

Claims may be submitted whenever eligible expenses exceed your deductible of $50 per year (single) or $75 (family of two or more). The deadline to submit a claim for expenses in one calendar year is December 31 of the following year.

HOW TO FILE A CLAIM

Please fill out the other side of this form and attach receipts. Photocopies are not acceptable.

WHAT IS COVERED?

1. DRUGS: Prescription drugs must be covered by Pharmacare to be eligible. Check with your pharmacist when you purchase your prescription and submit the original Pharmacare receipts with this form.

2. HOSPITAL: For acute care general hospital, spouses and dependents only. Receipts must be submitted with an itemized statement from the hospital showing:
a) date admitted
b) date discharged
c) amount paid per day
d) letter from doctor when claiming private or semi-private room.

3) AMBULANCE: Cost of emergency ambulance service.

4**) OUT OF PROVINCE**: In the event of an unexpected injury or illness, submit all receipts for physician's services or hospital charges to the Medical Services Plan (which has a 90-day deadline). After receiving a MSP statement, submit that statement, along with copies of receipts, to the Benefit Fund. There is a lifetime limit of $5,000 per family member.

5) PHYSIOTHERAPIST, MASSAGE THERAPIST, PODIATRIST, CHIROPRACTOR OR NATUROPATH: Fees for registered physiotherapists, massage therapists, podiatrists, chiropractors, naturopaths and acupuncturists up to a maximum
$500 payable per year per member or dependent for each listed service. Receipts must be supported by an itemized statements showing:
a) date of each treatment
b) amount charged for each treatment

6) EYEGLASSES: (including lenses, frames and contact lenses to a maximum of $300 in each 24-month period for each member of the family.

8) EXPENSES for other services should be submitted with a letter from the recommending doctor giving details of the disability and the reason why the service or item is necessary.

Mail completed form and all necessary receipts to:

UNITED FISHERMEN'S BENEFIT FUND
#4 – 830 14th Ave
Campbell River, V9W 4H4
Cell: 778 645 0578