#208 - 3970 Hastings Street, Burnaby, BC V5C 6C1
Phone: 604-293-1974, Toll Free: 1-800-345-5515

CLAIM FORM

PERSONAL INFORMATION (be sure to complete all fields)

EMPLOYER NAME: ______________________________ PLAN NUMBER: ______________________

EMPLOYEE NAME: ______________________________ DATE OF BIRTH: ______________________ yyyy/mm/dd

HAS YOUR ADDRESS CHANGED IN THE PAST YEAR? ☐ **Yes** ☐ **No**

If Yes, NEW ADDRESS: ______________________________ EMAIL: ______________________

CITY: ______________ PROV: __________ POSTAL CODE: ________ PHONE NO.: ______________________

Is claim being made for Worksafe BC Benefits? ☐ Yes ☐ No	Date of Accident (yyyy/mm/dd):	
If treatment was required due to accident, how did the accident happen?		

Do you, your spouse or dependents have any other Extended Health Insurance coverage, under which the expenses being claimed are eligible? ☐ Yes ☐ No

If Yes, Name of Other Insurance Company: ______________________ Group No. ____________ Certificate No.: ____________

If Yes, Name of Policyholder: ______________________ Spouse's Date of Birth: ______________ yyyy/mm/dd

Attach all ORIGINAL receipts, copies will not be accepted
You must attach a copy of the "Explanation of Benefits" from your alternate carrier
NOTE: Photocopies of receipts will be allowed for Co-ordination of Benefit (COB) claims only

CLAIM SUMMARY

Patient Name	Date of Purchase or Service	Description/Type of Expense	Charge	**FOR OFFICE USE ONLY**
		TOTAL: $		

AUTHORIZATION AND CONSENT

I certify all information submitted is true and complete. I have not claimed and will not claim these expenses under any other insurance plan unless indicated above. I acknowledge my understanding of the purpose for which personal information is collected, used, and disclosed and consent to use of this information for myself and/or any covered dependent in accordance with the privacy protection practices of Pacific Rim Administration Services Ltd. or any other parties as required in order to administer and/or confirm the accuracy of this claim. I understand I may revoke my consent at any time. A photocopy of this authorization and consent shall be as valid as the original. This consent complies with federal and provincial privacy laws.

Signature of Claimant: ______________________________ Date: ______________________

DIRECT DEPOSIT (for first request or if making a change, please include a VOID personal cheque)

○ Register me ○ Change my details ○ Use my info on file

All correspondence will go to the address we have on file, unless otherwise indicated above.