PACIFIC BLUE CROSS™

DO NOT WRITE IN THIS SPACE

Extended Health Care Standard Claim Form

Mailing Address
PO Box 7000
Vancouver BC
V6B 4E1

Street Address
4250 Canada Way
Burnaby BC

Member Information

Member's ID number	Policy number	Member's company name
	E902780 - Class 1	Constructions & Specialized Workers Benefit Plan

Member's last name	Member's first name	Employment status	Daytime phone number (10 digits)
		☐ Full time ☐ Part time ☐ Retiree ☐ Student	

Member's address/city/province/postal code

Check this box if this is a new address ☐

Member Consent & Declaration *(This section MUST be signed before submitting)*

I understand that the personal information provided on this claim, as well as any other personal information currently held by Pacific Blue Cross about me and my eligible dependents, will be used to determine eligibility for this benefit, assess and pay claims. I hereby acknowledge and agree that the personal information may be exchanged between Pacific Blue Cross and a health care professional, practitioner, institution or health benefits provider, government and regulatory authorities or insurer when needed for the purposes stated above or where reasonably necessary for the purposes of my enrolment or coverage under this group plan, or where required or permitted by law. I consent to the disclosure of my personal information by Pacific Blue Cross to my employer or plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I may refer to the PBC Privacy Policy at ***www.pac.bluecross.ca*** *for more details.*

I understand that the personal information will be kept confidential and secure. I understand that I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered. I understand why the personal information is needed and I am aware of the benefits and risks of consenting or refusing to consent to disclosure. I have read and understand this Member Consent and Declaration.

Signature	Date (yyyy/mm/dd)
X	

If the claimant is under 18 years of age, the member's signature is required.

Other Coverage

Do you or your dependents have other insurance to cover these benefits? ☐ Yes ☐ No

Name of the other insurance company	Policy number

ID number	Name of member with other insurance company

Employment status
☐ Full time ☐ Part time ☐ Retiree ☐ Student

Effective date (yyyy-mm-dd)	Cancellation date (yyyy-mm-dd)

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

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

Is this a WorkSafe BC (WCB) case? ☐ Yes ☐ No

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

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

☑ Check boxes below next to claims that are related to accidental or occupational injuries.

If any of these expenses are due to a medical emergency while you were outside of the province where you live, visit CARESnet® to download an Out of Province Claim *form or contact Pacific Blue Cross.*

Expense Information

	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)	Date of each purchase or service or hospital admission and discharge dates (yyyy-mm-dd)	Amount paid	Provider of service or prescriber of medication	Nature of illness or injury*	☑ See above
1									☐
2									☐
3									☐
4									☐
5									☐
6									☐
7									☐
8									☐
9									☐
10									☐
11									☐
12									☐

*Optional, but may result in refusal or delay of claim if not provided.

Total claim (optional): $0.00

0332.001 10-60-020 04/13 CUPE 1816