SUPPLEMENTARY HEALTH EXPENSE

MAIL ALL CLAIM FORMS TO:
BENEFIT PLAN ADMINISTRATORS (ATLANTIC) LIMITED
38 Solutions Drive, Unit 100
Ravine Centre Two
Halifax, Nova Scotia B3S 0H1

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.

Member's Name | Identification Number | Date of Birth (Day Mo. Yr)

Member's Address (No. and Street, City, Province, Postal Code) | Telephone No. ( )

IS THIS A CHANGE OF ADDRESS FROM YOUR LAST CLAIM SUBMISSION: YES(_) NO (_). IF YES, PLEASE ADVISE EFFECTIVE DATE OF CHANGE: DD / MM / YY

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

	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