CANADA WEST CONSTRUCTION UNION

HEALTH SPENDING ACCOUNT

CLAIM FORM

ATTACH ALL **ORIGINAL** BILLS, RECEIPTS, STATEMENTS, ETC. COPIES WILL BE NOT BE ACCEPTED AND THE CLAIM WILL BE RETURNED

NAME OF UNION: **CANADA WEST CONSTRUCTION UNION** PLAN NUMBER: _____

EMPLOYEE'S NAME: _____ PHONE NO.: _____

MAIL CHEQUE TO:

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

Is claim being made for Worksafe BC Benefits? ☐ Yes ☐ No	Is claim being made due to an automobile insurance? ☐ Yes ☐ No		
If treatment was required due to an accident, how did the accident happen?	Date of Accident: DD/MM/YYYY	Time: AM/PM	Where did accident happen? ☐ At work ☐ At home ☐ Elsewhere

Do you, your spouse or dependent children 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 Policy Holder: _____ Spouse's Date of Birth: _____ DD/MM/YYYY

NOTE: Photocopies of receipts will be allowed for Co-Ordination of Benefit (COB) claims. You must also attach the original "Explanation of Benefits" from your alternate carrier.

DEPENDENT INFORMATION

Patient Name	Does patient reside with you?		If child is 19 or over: Full-time Student?		Handicapped?	
	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

CLAIM SUMMARY

Patient Name	Date of Purchase or Service	Description	Nature of Illness	Charge		FOR OFFICE USE ONLY
			TOTAL:	$		

I certify that the statements above are complete and true and that all attached receipts represent no duplication of charges previously submitted.
I authorize:

1. Physicians, hospitals and/or any other service providers to exchange full information and records deemed relevant to this claim with Pacific Rim Administration Services (P.R.A.S.), its agents, representatives and/or its consultants and/or the insurer(s), their representatives, agents, and/or consultants for the purposes of assessing, adjudicating and/or managing this claim;
2. P.R.A.S. to exchange information with the insurer(s) and/or its agents or representatives, policyholder/plan administrator and agent of record with regard to any group statistical information that may include information concerning claims paid on my behalf or on behalf of my eligible dependants (other than specific details relating to medical condition(s)) for the purpose of negotiating group renewals, premiums/deposits and benefits management;

I understand all claims made under this Group Plan are submitted through the plan member. P.R.A.S. may exchange information about these claims with the plan member or any person acting on his or her behalf (as deemed necessary) for the purpose of confirming eligibility and assessing and managing the claim.

Signature of Claimant: _____ Date: _____

Email or Mail Forms To:

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