THE PBAS GROUP

101-46 Hopewell Way NE
Calgary, AB, T3J 5H7
Phone: 1-866-342-3513
Email: calgary@pbas.ca

UFCW Local 401 A VOICE FOR WORKING ALBERTA

REAL CANADIAN Superstore

STATEMENT OF EXPENSES FOR HEALTH CARE BENEFITS

TO BE CONSIDERED AN ELIGIBLE EXPENSE, CLAIMS MUST BE RECEIVED WITHIN 12 MONTHS FROM THE DATE EXPENSE WAS INCURRED OR THE DATE YOUR PLAN TERMINATED USING THE DATE OF SERVICE OR THE DATE SUPPLIES WERE PURCHASED. YOUR CLAIM FORM MUST BE COMPLETED IN FULL.

Plan Name	Policy Number	Member Certificate
UFCW Local 401 Real Canadian Superstore Benefit Trust Fund	840	

Member Name	Date of Birth (D / M / Y)	Email Address

Mailing Address No. and Street	City	Province	Postal Code

Coordination of Benefits

Do you have another plan that provides Benefits for you or dependants?		Yes □		No □
If yes, indicate:	Name of the Insurance Provider			Policy Number
	Type of Coverage	Health Only □	Dental Only □	Both □
	Policyholder's Name (if applicable):			Date of Birth:

Patient Information				Drug Expenses		Other Expenses	
Patient Name	Date of Birth D	M	Y	DIN or Drug Name	Total Charge	Type Of Expense	Total Charge
				Total:		Total:	

PLEASE ATTACH RECEIPTS AND DOCTOR REFERRALS*, IF APPLICABLE. PHOTOCOPIES ARE ACCEPTED.

In signing this Statement of Expenses, I certify that the charges for the medical supplies which are listed above and for which the bills are attached were incurred by myself or one of my eligible dependants upon recommendation and approval of the attending physician (if required under the terms of the Plan Text or where applicable) and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my eligible dependants. I declare that my statements in this expense reimbursement request are accurate and true.

On behalf of myself and my eligible dependants, I authorize my group benefit provider, PBAS, and any of its affiliates or re-insurers to exchange the personal information contained on this form or any other benefit related personal information contained in their files now or in the future respecting me or any of my eligible dependants. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as I and my dependants are covered by, or are claiming benefits under the present group contract, or any modification, renewal or reinstatement thereof. I agree that a photocopy or electronic copy of this authorization is as valid as the original.

Date _____ Signature of Member _____ Telephone Number _____