

## NDT INDUSTRY HEALTH BENEFIT PLAN – POST-RETIREMENT BENEFITS

4250 CANADA WAY, BURNABY, BC V5G 4W6 Tel: (604) 299-7482 Fax: (604) 299-8136  
Toll Free: 1-800-663-1356 www.ndtbenefits.org

### EXTENDED HEALTH BENEFITS CLAIM

**52567**

Group/Policy No. \_\_\_\_\_ I.D./Certificate Number \_\_\_\_\_

Member Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Member Address \_\_\_\_\_

Have you worked for a Participating Employer in the last 6 months? Yes  No   
If yes, please indicate the most recent month that you worked for the Participating Employer: \_\_\_\_\_

Complete form, attach receipts and forward to:  
**NDT Industry Health Benefit Plan**  
4250 Canada Way, Burnaby, BC V5G 4W6  
or submit by Fax: (604) 299-8136  
or Email: health@datownley.com  
**Direct Deposit is now available**  
**Contact the Administrator for details**

PharmaCare Registration No. (BC Residents Only)

#### LIST EXPENSES BELOW, GROUPED BY INSURED PERSON, IN DATE ORDER

*Please include all applicable receipts. In case of dual coverage, send Statement of Payment from primary insurer along with photocopies of original receipts.*

**\*PLEASE NOTE: Receipts will not be returned. Please retain copy if required.**

Name (Employee or Insured Dependent)	Relationship to Employee	Birth Date yr/mo/day	Date of Purchase yr/mo/day	Drug/Service Provided	Prescription DIN	Amount Charged
						\$

Additional space on reverse

NOTE: Birthdate for all dependents (spouse & children) must be given.  
If dependent is age 21 or older, indicate school he/she is attending. School: \_\_\_\_\_

Full Time       Part Time

**Are any benefits or services provided under any other insurance or supplementary health plan?**       **YES**       **NO**

If "Yes", indicate:

**Policy No.:** \_\_\_\_\_      **Name of insuring agency:** \_\_\_\_\_

**Name of Insured:** \_\_\_\_\_      **I.D./Certificate Number:** \_\_\_\_\_      **Date of Birth (y/m/d):** \_\_\_\_\_

Are charges covered by the Provincial Hospital and/or Medicare Plan?       **YES**       **NO**

If "Yes", when did the claim exceed the Plan's maximum? \_\_\_\_\_

Are any of the above expenses the result of a motor vehicle accident/Workers Compensation claim?       **YES**       **NO**

If "Yes", please specify and explain: \_\_\_\_\_

I understand that D.A. Townley collects personal information to assess eligibility for benefits; to determine and adjudicate benefits; to determine the cost and financially manage these benefits, as well as to meet regulatory or contractual requirements relating to such benefits and related services provided. I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union or insurance company to release to D.A. Townley any additional information required in connection with this claim. The information released through this authorization will be used for claims adjudication purposes and statistical analysis.

\* Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Employee or Insured Dependent)	Relationship to Employee	Birth Date yr/mo/day	Date of Purchase yr/mo/day	Drug/Service Provided	Prescription DIN	Amount Charged
						\$

Please complete the reverse side of this form IN FULL and send together with original receipts to:

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