PACIFIC BLUE CROSS

DO NOT WRITE IN THIS SPACE

Benefits provided by HBT — HEALTHCARE BENEFIT TRUST — BENEFIT FROM EXPERIENCE

HEALTH CLAIM FORM

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | www.pac.bluecross.ca

Use this form to submit a claim for all medical expenses and services. **Please enclose all supporting documentation, original receipts and complete all parts of this form to avoid delays in processing your claim.** See page 2 for important information about preparing your claim.

PART 1 — MEMBER INFORMATION

Policy number	Benefits ID number	Name of plan, company name or Plan sponsor (if applicable)
50000	82220382	Healthcare Benefit Trust

First name	Last name	Employment status	Daytime phone number (10 digits)
Graeme	Smith	☒ Full-time ☐ Part-time ☐ Retiree ☐ Student	604-682-2344 x624

Street address	City	Province	Postal code	New address?
#204 - 3784 W. 16th Ave.	Vancouver	BC	V6R 3C4	☐ Yes

PART 2 — OTHER INSURANCE COVERAGE: Complete this section if you or your spouse are covered under another plan

Other insurance coverage	Coverage start date (mm-dd-yyyy)
☐ Pacific Blue Cross ☒ Other insurer: Plan Direct	2008-ish ??

Member's policy number	Member's ID number	Plan member	Cancellation date if applicable (mm-dd-yyyy)
0156	724451	☐ Same as above ☒ Spouse	

Spouse's first name if spouse's plan	Spouse's last name if spouse's plan	Employment status of spouse	Spouse's birthdate (mm-dd-yyyy)
Nancy	Dobie	☒ Full-time ☐ Part-time ☐ Retiree ☐ Student	03-04-1968

PART 3 — INFORMATION ABOUT YOUR CLAIM

Please provide the first name and birthdate of all eligible dependents with a claim. For each dependent, add up all receipts and provide the total amount of their expenses.

If any expenses are the result of a medical emergency outside your province, visit CARESnet® to download an *Emergency Out-of-Province Claim Form*.

Remember to enclose all supporting documentation and original receipts. You can mail your claim to us or drop it off at our Burnaby office.

FIRST NAME	BIRTHDATE	TOTAL EXPENSES
Graeme	(mm-dd-yyyy) 7/31/1968	$ 32.44
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	GRAND TOTAL	$ 32.44

1. Are the expenses you're claiming:
   - The result of a workplace injury? (i.e., WorkSafeBC) ☐ Yes ☒ No
   - The result of a motor vehicle or other accident? ☐ Yes ☒ No
   - Are you seeking damages from a 3rd party? N/A ☐ Auto ☐ WorkSafeBC ☐ Other: _____

   (If yes to any of the above, please complete an *Accident or Injury Reimbursement Agreement Form* available on CARESnet.)

2. Have any of your expenses been paid by another insurance company? (If yes, include photocopies of your receipts and the claim statement provided by the other insurance company.) ☐ Yes ☒ No

3. Apply any unpaid balance(s) to your Health Spending Account? (If applicable, see page 2 for more information.) ☐ Yes ☒ No

PART 4 — MEMBER CONSENT AND DECLARATION

Pacific Blue Cross (PBC) does not return receipts. Please save our Explanation of Benefits for income tax purposes. If you also have coverage with another insurance company, make a photocopy of all receipts before sending the originals to PBC. I certify that I and/or my dependents incurred these expenses for medically necessary health care. All information is correct. I consent to PBC, as the claims paying agent of the Healthcare Benefit Trust (the Trust), using this personal information to adjudicate my claim and disclosing this information when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand and consent that the personal information provided by me and my dependents under this group plan may be disclosed to the Trustees of the Trust and their agents. I acknowledge and agree to the disclosure of this personal information by PBC to my employer/plan sponsor when required or permitted by law for the purpose of investigation and prevention of fraud and/or plan abuse. 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 also authorize PBC or its agents access to any relevant information required to adjudicate this claim.

If I am making a claim under my Health Spending Account (where applicable), I acknowledge that the person(s) for whom I am making a claim are eligible and I accept full responsibility to ensure all expenses submitted for payment from my Health Spending Account are allowable medical expenses as defined under the Canadian Income Tax Act. I understand I am responsible for payment of any taxes that arise from reimbursement of these expenses. I also agree my plan sponsor may have access to a summary of the total amounts claimed by me for the purposes of tax or administrative reporting. If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s). I have read and understand this member consent and declaration.

Member's signature	Date (mm-dd-yyyy)
X Graeme Smith	12/31/2016

0412.005 - 10.60.035 - 11/15 CLIPF 1816

MTM ENTERPRISE LTD.
1125 DAVIE STREET
VANCOUVER, BC V6E 1N2 CANADA
Store # 0272 Phone: 604 685 6445

Healthwatch

SHOPPERS DRUG MART

PERSONAL MEDICATION HISTORY

GRAEME SMITH
Allergies: NO KNOWN ALLERGIES

PLEASE CALL 24 HOURS IN ADVANCE FOR REFILLS

9563875 LAMISIL CRM 1% Ref:0 2016-04-25

Printed: 2016-04-25

MTM ENTERPRISE LTD.
1125 DAVIE STREET
VANCOUVER, BC V6E 1N2 CANADA
Store # 0272 Phone: 604-685-6445

Healthwatch

SHOPPERS DRUG MART

OFFICIAL PRESCRIPTION RECEIPT

SMITH, GRAEME
204-3784 16TH AVE W
VANCOUVER, BC V6R 3C4
604-736-1086 PHN 0009048736142

DR. T. WONG
Lic: 17684

Date: 25 Apr 2016
Rx: 9563875 Ref:0 Tx: 19090792 9

LAMISIL CRM 1%
TERBINAFINE HCL 1% Mfr: NOV
30 G Days: 7 DIN 02031094

Pricing: PNET
Total: 32.44 Cost: 20.84
Fee: 11.60

PNET Pays: 0.00

Pharmacist's Signature: _____
BC00000F97

Patient Pays:
$32.44

SHOPPERS DRUG MART

MTM Enterprise Ltd. 0272
1125 DAVIE ST, VANCOUVER, BC, V6E 1N2
604-669-2424

0272 1002 516015 500001 3

SALE

PRESCRIPTIONS 19090792	N X	32.44
	SUBTOTAL:	32.44
1 Item	TOTAL:	$32.44
	CASH:	40.00
	CHANGE DUE:	7.56
	ROUNDED CHANGE:	7.55

GST #: 87027 0162 RT0001

9990202721002005160154

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YOU RECEIVED IN OUR STORE TODAY
and you could win 1 of 50 prizes
of $1000 in Gift Cards
DOUBLE YOUR CHANCES
of winning by going online at
www.surveysdm.com
or call 1-800-701-9163
Certificate Number:01428007-7102026
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Retain Receipt for return within 30 days.
Visit shoppersdrugmart.ca for exclusions.

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