

**BOILERMAKERS LODGE NO. 191 BENEFIT PLAN***Hosted by the Boilermakers' National Health Plan (Canada)*

45 McIntosh Drive, Markham, ON L3R 8C7

Phone: 1-800-263-3564 Fax: 905-946-2535

email: questions@boilermakers191benefits.org

**EXTENDED HEALTH BENEFITS CLAIM**

Office Use Only

Complete form, attach receipts and forward to:

**Boilermakers Lodge No. 191 Benefit Plan****45 McIntosh Drive, Markham, ON L3R 8C7**

or submit by Fax: 905-946-2535

or Email: questions@boilermakers191benefits.org

Direct Deposit is available.

Contact the Administrator for details.

Group/Policy No.

I.D./Certificate Number

Member Last Name

First Name

Member Address

Name of Employer or Union Affiliation

PharmaCare Registration No.

**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 prime insurer along with photocopies of 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 &amp; 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:

Privacy Statement: I authorize the Boilermakers Lodge No. 191 Benefit and Pension Plans (together called "the Plans"), their administrator Employee Benefit Plan Services Limited, and providers working with the Plans or administrator to collect, maintain, use and disclose my personal information that is necessary for the administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plans may collect, maintain, use and disclose my personal information with relevant persons or organizations (employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal counsel, other plans or unions, pharmacies, regulators, re-insurers) in order to manage the Plans and entitlement to the benefits of the Plans, and may include information such as financial, health or benefits related information. Questions related to the Privacy Statement should be directed to the Privacy Officer

★ 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 all applicable receipts to:

**BOILERMAKERS LODGE NO. 191 BENEFIT PLAN**  
**45 McIntosh Drive**  
**Markham, ON L3R 8C7**  
or submit by Fax: 905-946-2535  
or Email: [questions@boilermakers191benefits.org](mailto:questions@boilermakers191benefits.org)