PACIFIC FIRST–submit DENTAL and EXTENDED HEALTH claims on this form – but must use separate forms (EH on one copy, Dental on a separate copy)

215 – 3993 Henning Drive, Burnaby, BC V5C 6P7 Tel: 604 - 293-1974 or toll-free 1-800-345-5515 Fax: 604 - 293-0344

ATTACH **ORIGINAL** BILLS, RECEIPTS, STATEMENTS ETC. COPIES WILL BE DENIED AND THE CLAIM WILL BE RETURNED **P6835**

WAWANESA LIFE POLICY NO. **G2162** CERT. NO. _____ EMPLOYER **DENBOW TRANSPORT**
please leave blank

EMPLOYEE'S NAME: _____ DATE OF BIRTH _____

ADDRESS: C/O 215 – 3993 Henning Drive, Burnaby, BC V5C 6P7 PHONE NO: 1-800-345-5515 D M Y

ALL OF THE FIELDS IN BOX BELOW MUST BE COMPLETED AND THIS FORM SIGNED ..... OR IT WILL BE RETURNED FOR COMPLETION

Is claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No	Is claim being made to an automobile insurance? ☐ Yes ☐ No		
If treatment was required due to an accident, how did the accident happen?	Date of Accident D/M/Y	Time ☐ AM ☐ PM	Where did it happen? ☐ At work ☐ At home ☐ Elsewhere

Have you, your spouse or dependent children any other Extended Health Insurance coverage, under which the expenses being claimed are eligible? ☐ Yes ☐ No

If yes, Name of Policyholder_____Group Number_____Certificate Number_____Spouse's Date of Birth

Name of other Insurance Company_____(D/M/Y)_____

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	Relationship	Date of Birth D M Y	Does patient reside w/you? YES NO	If child is 19 or over: Full-time student? YES NO	Handicapped? YES NO
			☐ ☐	☐ ☐	☐ ☐
			☐ ☐	☐ ☐	☐ ☐
			☐ ☐	☐ ☐	☐ ☐
			☐ ☐	☐ ☐	☐ ☐
			☐ ☐	☐ ☐	☐ ☐

CLAIM SUMMARY

Patient Name	Date of Purchase or Service	Name of Drug or Type of Service		Charge		
		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.

Date:_____ Signature of Employee:_____

All correspondence will go to the address we have on file, unless otherwise indicated on a separate piece of paper.