NDT Benefits
Career — Health — Security

# NDT Industry Health Benefit Plan

45 McIntosh Drive. Markham, ON. L3R 8C7 Tel:1-800-263-2564 Fax: 905-946-2535
www.ndtbenefits.org

## EXTENDED HEALTH BENEFITS CLAIM

Complete form, attach receipts and forward to:
**NDT INDUSTRY HEALTH BENEFIT PLAN**
45 McIntosh Drive. Markham, ON. L3R 8C7
or submit by Fax: 905-946-2535
or Email: medical@ndtbenefits.org
**Direct Deposit is now available**
**Contact the** Plan **Administrat**ion Office **for details**

I.D./Certificate Number

Member Last Name First Name

Member Address

Name of Employer or Union Affiliation

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 |
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Additional space on reverse

NOTE: Birthdate for all dependents (spouse & children) must be given.
If dependent is age 21 or older, indicate school they are 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: The Plans will collect, maintain and communicate only the Personal Information considered necessary for the administration of the Plans. Personal Information will be protected pursuant to the applicable legislation. The Plans may use and exchange information with relevant persons and organizations including the Trustees, institutions, investigative agencies, unions, insurers, re-insurers, auditors, legal counsel, actuaries, payroll/payment providers, Plan administrators, and regulatory authorities in order to manage the Plans and entitlement to the benefits of the Plans. Questions related to the Privacy Policy should be directed to the Benefit Administration Office.

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


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Tel:1-800-263-2564

Fax: 905-946-255

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