Electrical Workers' Health & Welfare Fund ALBERTA

Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808 Email: claims@ebfa.ca

Supplementary Health Expense -

Physiotherapy, Chiropractic, Psychological, Osteopath, Naturopath, Podiatrist, Chiropodist, Christian Science Practitioner, Acupuncture, Massage Therapy

Section 1 - To Be Completed By Plan Member

Plan Policy Number: 6012

Plan Member – Last Name, First Name and Initial: EBFA Stakeholder Number:

Address: City/Province/Postal Code: Area Code and Telephone Number:

Birthdate (dd/mm/yy): Gender: ☐ Male ☐ Female

If Claim Is On Behalf Of An Eligible Dependent, Please Complete The Following

Dependent's – Last Name, First Name and Initial: Date of Birth (dd/mm/yy):

Relationship (i.e. spouse, daughter, son):

Directions / Provincial Plan Maximums / Documents Required

Claim forms must be signed and dated, or they will be returned for completion. Cash register receipts and debit receipts will not be accepted as an original paid receipt. You may send your claim form and receipts by facsimile to (780) 465-0808.

Supplementary Health Expenses are limited to a "Reasonable and Customary" per visit fee based on initial assessments and subsequent treatments and are also limited to a calendar year maximum per person. Coverage for the above Paramedical services will only be provided if the services are prescribed by your family physician (or specialist). Referrals are required each calendar year, for each claimant. Services are not covered unless performed by a practitioner with an acceptable designation (i.e. massage therapists must have 2200 hours / 2 years schooling program in order to meet the acceptable accreditation.)

The patient is responsible for securing this form and for any charges made for its completion. Failing to answer all questions on this form will delay payment of your claim. Please refer to your Health & Welfare Plan Booklet for a complete outline of the services allowed/exclusions under the Plan. You may also view the Plan Booklet on the website at www.ebfa.ca.

Co-insurance Information

Do you or your Dependents have any other coverage which may pay a benefit for any of the expenses being claimed on this form?
□ Yes □ No If yes, please provide the following information:

Plan Member – Last Name, First Name and Middle Name Date of Birth (dd/mm/yy)

Insurance Company Address Postal Code Area Code and Telephone Number Policy Number

Are you claiming any expense resulting from injuries or illness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law? □ Yes □ No

Does the person for whom you are submitting this claim have coverage through their Provincial Plan? □ Yes □ No
Provincial Plan Number _____ in the Province of _____.

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Page 2 – Supplementary Health Expense

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Assignment Of Benefits To The Supplier

I hereby authorize the Administrator of the Electrical Industry Insurance Benefit Trust Fund of Alberta to issue payment of all benefits relating to this claim directly to the supplier as stated in Section 2 below. (Do not sign this section if you are attaching original paid receipts.)

_____

Signature of Plan Member Date signed (dd/mm/yy)

Privacy Issues

I certify the charges for the medical supplies which are listed herein and for which the bills are attached were incurred by myself on account of myself or one of my eligible family members upon the recommendation and approval of the attending physician and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my eligible family members.

I hereby authorize the release of information contained in, or pertaining to this claim to the Insurer, Board of Trustees, Medical Consultant, or any of their authorized representatives for purposes of settlement of this claim.

Signature of Plan Member Date signed (dd/mm/yy)

Section 2 - To Be Completed By Practitioner or Physician

Please print clearly: Patient's Name: _____

Practitioner or Physician - Last Name, First Name and Initial Confirm if: Certified, Registered, Chartered & Licence #

Address Postal Code Area Code and Telephone Number

Date treatment commenced (dd/mm/yy) Expected duration of treatment Type of treatment

Signature of Practitioner/Physician Date (dd/mm/yy)

Type of Treatment	Date of Service	Amount Charged