Employee Benefit Funds ADMINISTRATION LTD.

nexgenRx
Drug Claim Department
145 The West Mall,
P.O. Box 110 U
Toronto, ON M8Z 5M4

Toll Free 1-866-424-0257
Facsimile: (647) 722-2934
Email: memberhelp@nexgenrx.com

PRESCRIPTION DRUG – Direct Reimbursement Form

Section 1 – To Be Completed By The Plan Member

Plan Policy Number: 6012

Plan Member's 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

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:

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

Insurance Company: Address: Postal Code: 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

Directions / Documents Required

Please attach all original paid receipts to this form if you wish to be reimbursed. The receipts must show the item has been paid in full. Cash register receipts and debit receipts will not be accepted as an original paid receipt. Please note that there is a calendar year maximum per person on all eligible prescription drugs. Please contact the Fund Office for further details.

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 (dd/mm/yy)

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List all enclosed receipts.

Participant's Name	Gender M/F	Birthdate (dd/mm/yy)	Purchase Date (dd/mm/yy)	Din #	Drug Name	Amount Charged
Name of Spouse						
Name(s) of Children						

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