0217

Health Benefits Trust Fund
Cost Plus Claim Form

Incomplete forms will be returned. Please refer to the "Guide to Submitting Cost *Plus* Claims" before submitting your claim.

- Print clearly, in ink. **Please retain your original receipts and Insurer's Claim Statement (Explanation of Benefits) for your records. Receipts should not be attached to your claim form.**
- The Cost Plus Benefit may be used to claim medical expenses incurred by you and/or your eligible dependents. These expenses must meet the Canada Revenue Agency's (CRA's) tax deduction guidelines for eligible medical expenses. Please ensure you retain all your receipts.
- It is your responsibility to determine if medical expenses are allowable under CRA's rules and guidelines. If you are in doubt about the eligibility of an expense, you should contact the CRA for an official ruling at 1-800-959-8281.
- Sign and date the form and email the claim form to **insurance@doctorsofbc.ca** for processing.

1. Plan Member Information

The Member ID number is provided on your Statement of Coverage.

Last Name | First Name | Middle Initial | Member ID

Address:

City | Province | Postal Code

2. Plan Member Declaration and Authorization

(MUST BE COMPLETED)

I certify that all goods or services being claimed have been received by me or my dependents. I certify that the information in this form is true and complete, to the best of my knowledge. By submitting this claim form, I understand that I am requesting payment be made for the expenses submitted, in accordance with Cost Plus benefit claiming guidelines**. I accept full responsibility to ensure that all expenses incurred and submitted are allowable medical expenses as defined under CRA's guidelines**. I understand that the personal information provided herein, as well as any other personal information currently held by the Doctors of BC (BCMA) about me and my eligible dependents will be used to verify, determine eligibility for, and pay claims under this Plan. I authorize any health care provider or other relevant person to release or exchange information if required by the Trust Fund or its Administrators to process this claim. I understand that my personal information will be kept confidential and secure in accordance with the Doctors of BC's privacy policies and procedures. I agree that a photocopy of this authorization shall be as valid as the original.

X _____ mm dd yyyy

Plan Member's Signature

3. Employer / Corporation Authorization

(MUST BE COMPLETED)

The undersigned hereby authorizes the Health Benefits Trust Fund Administrators to pay the eligible health and/or dental expenses through the Cost Plus Benefit for the above-named claimant.

X _____ mm dd yyyy

Signature of Employer or Authorized Signature, if Corporation

Name of Employer or Corporation **(please print clearly)**

Please turn over and complete detailed claim information

4. Claim Information

List each item separately (attach additional sheets if required). If partial payment has been made by Canada Life or another Insurer, ensure you retain the **entire** Claim Statement/Explanation of Benefits, including explanatory codes, in your files.

PLEASE NOTE: Do not attach, receipts, Claims Statements, credit card receipts or cash register slips.

	Name of Person for whom expense was incurred (Patient)	Relationship to Physician or Employee	Date of Service mm/dd/yyyy	Description of Service e.g. Rx, Dental	Out-of-pocket expense paid by you	
1						
2						
3						
4						
5						
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21						
22						
23						
24						
				Total Amount Claimed:		

5. Claim Withdrawal

TO BE COMPLETED BY BCMA STAFF – DO NOT WRITE IN THIS AREA

Insured Code:_____ Effective Date:_____ **Total Eligible Claim:**

Current Yr Limit: _____ Prior Yr Limit:_____ Administration Fee

TOTAL CLAIM WITHDRAWAL