Waterfront Employers
British Columbia
400 – 349 Railway Street, Vancouver, BC V6A 1A4
t (604) 689 7184 | f (604) 681 7447

LONGSHORE EXTENDED HEALTH & VISION CLAIM FORM

IMPORTANT:

- Print clearly and complete all sections.
  - Incomplete forms or claims sent without required documents may delay claim processing.
- Attach receipts for each expense claimed.
  - Keep copies as your receipts will not be returned.
- If you submitted this claim to another insurance company, attach a copy of their reimbursement statement and copies of your receipts.
- Do not use this form for Prescription Drug or Dental claims.
  - Download a Prescription Drug claim form online; or,
  - Ask your dental provider for a Standard Dental Claim Form.

HOW DO I LEARN MORE ABOUT MY BENEFITS?

- Visit www.longshoreplans.ca for information about your benefits and downloadable forms. Password: longshore#1

HOW DO I SUBMIT A CLAIM?

- **EMAIL:** extendedhealth@webc.ca
- **FAX:** (604) 681-7447
- **MAIL OR IN-PERSON:**
  Waterfront Employers of BC
  #400 - 349 Railway Street
  Vancouver, BC V6A 1A4

FOR MAIL OR IN-PERSON SUBMISSION:

- Place official receipts flat in envelope.
- Remove all staples, paperclips, tape.
- Cashier or Interac receipts are not required.

1. INFORMATION ABOUT YOU THE MEMBER

NAME	EMPLOYEE #	BIRTHDATE *(DD-MM-YYYY)*

ADDRESS *(TICK BOX TO UPDATE WEBC RECORDS WITH NEW ADDRESS)*	CITY	PROV

POSTAL CODE	HOME PHONE	CELL PHONE	EMAIL

2. COMPLETE THIS SECTION IF YOU OR YOUR SPOUSE ARE COVERED UNDER ANOTHER PLAN

OTHER PLAN HOLDER'S NAME	BIRTHDATE *(DD-MM-YYYY)*	TYPE OF COVERAGE
		SINGLE FAMILY

INSURANCE CARRIER	CONTRACT NUMBER	ID NUMBER

ARE YOU CLAIMING EXPENSES NOT COVERED UNDER ANOTHER PLAN? IF YES, PLEASE SPECIFY

3. COORDINATION OF BENEFITS

- Send your claim to your primary plan first. Once processed, your primary plan will issue you with a reimbursement statement. You can claim any unpaid amount by sending copies of your receipts, the reimbursement statement and completed claim form to your other plan.
- If you are submitting claims for your children, send those claims first to the plan of the parent whose birthday occurs earlier in the year.

TICK BOX IF YOU SUBMITTED THIS CLAIM TO ANOTHER INSURANCE COMPANY AND ARE ATTACHING A COPY OF THE EXPLANATION OF BENEFITS OR REIMBURSEMENT STATEMENT.	❗ HAVE YOU OR YOUR SPOUSE CANCELLED YOUR OTHER INSURANCE PLAN OR HAS IT TERMINATED? YOU WILL NEED TO PROVIDE PROOF OF DATE OF TERMINATION. **PLEASE CONTACT WEBC AS SOON AS YOUR OTHER INSURANCE PLAN ENDS.**

4. CLAIM INFORMATION

PLEASE SELECT ALL THAT APPLY:

I am claiming services related to an ICBC or other auto insurance case. CLAIM #:______________________

I am claiming services related to a WorkSafe BC case (WBC). CLAIM #:______________________

I am claiming services related to an accident.

I am claiming services related to a medical emergency that occurred during travel outside of Canada.

The services I am claiming are not related in any way to a motor vehicle incident, workplace incident, or any other accident where ICBC, WorkSafe BC, or any other liable third part may become involved, and it is not related to a medical emergency while travelling outside of Canada.

5. CLAIM DETAILS

PATIENT NAME *(FIRST AND LAST)*	BIRTHDATE *(DD-MM-YYYY)*

DO NOT USE THIS FORM FOR DENTAL OR PRESCRIPTION DRUG CLAIMS

SUBMIT ONE COPY OF THIS PAGE PER MEMBER OR DEPENDENT. ATTACH ADDITIONAL COPIES IF NECESSARY

	DATE OF SERVICE *(DD-MM-YYYY)*	DESCRIPTION *(PHYSIO/VISION/ETC)*	AMOUNT CLAIMED
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

REMEMBER TO ENCLOSE ORIGINAL RECEIPTS, SUPPORTING DOCUMENTATION AND REIMBURSEMENT STATEMENT FROM YOUR OTHER INSURANCE PLAN. INCOMPLETE FORMS MAY DELAY THE PROCESSING OF YOUR CLAIM.

6. MEMBER CONSENT AND DECLARATION

I certify all goods and services claimed have been received by me and/or my spouse or dependents, if applicable. I certify the information in this form is true, correct and complete to the best of my knowledge and does not contain a claim for any expense previously paid for by this or any other plan.

I understand the Waterfront Employers of BC will use the personal information specific to this claim, and any other personal information that they hold about me and my eligible dependents to determine eligibility for benefits and to pay claims. I acknowledge and agree that the personal information about me and my dependents may be collected, used and exchanged between the Waterfront Employers of BC and any other person or organization related to this claim or the administration of my benefit plan. This includes healthcare professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by the Waterfront Employers of BC to my Plan Sponsor when required or permitted by law or pursuant to contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.
If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Client Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan.

For claims submitted electronically, in place of signature, type first and last name in the Member's Signature section to confirm you acknowledge your Consent and Declaration.

THIS SECTION MUST BE SIGNED BY THE MEMBER IN ORDER FOR YOUR CLAIM TO BE PROCESSED

MEMBER SIGNATURE	PRINT NAME	DATE *(DD-MM-YYYY)*
X	**X**	

PLACE YOUR RECEIPTS FLAT AND LOOSE IN ENVELOPE WITHOUT STAPLES, TAPE OR PAPERCLIPS. INTERAC AND CASHIER RECEIPTS NOT REQUIRED.

SECTION FOR WATERFRONT EMPLOYERS OF BC STAFF USE ONLY

CLAIM NUMBER	CHEQUE DATE	AUTHORIZED BY	CLAIM TOTAL