Electrical Industry Insurance Benefit Trust Fund of Alberta
4211 – 95 Street NW, Edmonton, Alberta T6E 5R6
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Fax: (780) 465-0808 Email: claims@ebfa.ca

Supplementary Health Expense -

Physiotherapy, Chiropractic, Psychological, Osteopath, Naturopath, Podiatrist, Chiropodist, Christian Science Practitioner, Acupuncture, Massage Therapy, Speech 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: _____ Telephone Number: _____

Cell Phone Number: _____ Birth date (dd/mm/yy): _____ Gender: ☐ Male ☐ Female

Claimant Information:

Patient Name:	Date of Birth (dd/mm/yy):	Relationship to Plan Member:

Co-insurance Information

Do you or your dependents have any other coverage for the expenses being claimed on this form?
□ **Yes** □ **No** **If yes, please provide:**

Name of Insured: _____ Name of Insurance Company: _____

Date of birth (dd/mm/yy): _____ Plan Policy Number: _____

Plan Member ID Number: _____ Plan Effective Date: _____

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** _____**.**

Directions / Provincial Plan Maximums / Documents Required

Claim forms must be signed and dated, or they will be returned for completion.

A paid receipt is required. Cash register receipts and debit receipts will not be accepted as a paid receipt.

A co-insurance statement of payment or denial is required if the claimant has co-insurance.

The Seniors Alberta Blue Cross program may cover up to $200.00 for Chiropractic Services and up to $300.00 for Psychological Services from July 1 – June 30. Please attach co-insurance statement(s) if you are covered under this program.

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 year, for each claimant. The back of this form can be accepted as a referral if completed by a family physician or specialist, or chiropractor for chiropractic services only. 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). Paramedical services are paid based on the practitioner who performed the treatment and not the type of treatment provided (unless the practitioner has two acceptable designations, then payment will be made under the paramedical service that matches the treatment provided).

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.

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Page 2 – Supplementary Health Expense

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

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 covered expenses relating to this claim directly to the supplier named on the invoice. **(Do not sign this section if you are attaching paid receipts.)**

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

Privacy Issues

I certify the charges for the supplementary health expenses 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 medically necessary 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, Plan Administrator, Medical Consultant, Trustees 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 Physician or Practitioner

Please print clearly: **Patient's Name**: _____

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

Address: Postal Code: Telephone Number:

Type of treatment: Signature of Physician/Practitioner Date (dd/mm/yy)

Invoice/Receipt MUST be attached

Type of Treatment	Date of Service	Amount Charged