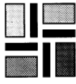


*Employee Benefit Funds Administration Ltd.*

Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-EBFA (780) 465-3232 (780) 465-2882
Toll Free 1-800-268-3649
Facsimile: (780) 465-0808

# Supplementary Health Expense -

Custom made Orthotics & Orthopaedic Shoe Benefit

## Section 1 – To be completed by Plan Member

**Plan Policy Number:** 6012

Last Name | First Name and Initial | I.D. #

Address | City/Province/Postal Code | 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

- The Plan Member must complete a claim form for each type of orthotic device.
- We recommend that the Plan Member/Dependents obtain a preauthorization prior to purchasing orthopaedic boots/shoes.
- Under the Plan rules, orthotic devices cannot be assigned to the supplier. We will require your original paid receipts.

## 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? □ No □ Yes
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? □ No □ Yes

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

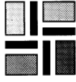
## Privacy Issues

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. I authorize the use of my Social Insurance Number for identification purposes.

---------------------------------------------------------------------------------------------------------------------------

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



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# Page 2 – Supplementary Health Expense

CUSTOM MADE ORTHOTICS & ORTHOPAEDIC SHOE BENEFIT

**Section 2 - Must be completed by either: a Physician, Podiatrist, Chiropodist or OPQ (Quebec only)**

**Instructions: Questions number 1. through 6. must be answered in full. Please print clearly.**

Physician, Podiatrist, Chiropodist's: Last Name First Name and Initial Specialty (as stated above)

Address/City/Province Postal Code Telephone Number (include area code)

Date treatment commenced (dd/mm/yy)

Patient's Name ____________________________________________

1.) Recommended Medical Item(s) Describe in detail.

2.) Diagnosis of medical condition

3.) Symptoms/chief complaint

4.) Description of the physical findings from the clinical examination

5.) A brief narrative description of the gait abnormality associated with the diagnosis

6.) The appliance will be used for (check one): ☐ Daily Activity ☐ Sports Purposes ☐ Daily Activity and Sports Purposes

Comments:

Signature of Physician Date (dd/mm/yy)