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

PRESCRIPTION DRUG – Direct Reimbursement Form

Section 1 – To be completed by Plan Member

Plan Policy Number: 6012

Plan Member's Last Name First Name and Initial I.D. #

Address City/Province/Postal Code 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? ☐ 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

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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Prescription Drugs – Direct Reimbursement Form

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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