IUOE Local 793 Drug and Supplementary Health Care Claim

Pension and Benefits Administered by OEBAC

A Introduction

➔ To make this application valid, you will need to attach:

- For Drug claims, the original receipts purchase showing prescription number, patient's name, date, drug name and DIN (Drug Identification Number).
- For Supplementary Health Care claims, the original receipts showing patient's name, date of service, practitioner's name, and type of service provided.
- For Physiotherapy claims, a Physician's diagnosis confirming the referral and that the need for treatment is not related to a Multiple Vehicle Accident.
- For Durable Equipment claims, a letter from the Physician describing the nature of the disability and providing a diagnosis, a description of how the particular service or equipment will improve or stabilize the patient's condition, and the length of time the equipment will be required.

Retain copies of your receipts for submission to any other benefits plan that you may have.

Please request, fill in, and return an updated Personal Information File (PIF) to notify OEBAC of <u>any changes</u> in information about: **(a)** you, the Plan Member; **(b)** your dependants; **(c)** any other health care plan that you or your dependants may have; **(d)** your beneficiaries; **(e)** your bank accounts; or **(f)** the individuals authorized to inquire about your benefits. By doing this on time, you will facilitate faster processing of your claims and reduce the chances of claim rejection.

B Plan Member's information

For office use only
ABCDEFGH

Full Name		From your OEBAC Benefits Card Group #: ☐ 793 ☐ 793X Certificate #:
Phone #	Email	Or, from your IUOE Local 793 Card Registration #:

C Claim information

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Please specify who this claim is for and indicate the type of claim with a "**D**" if it is for drugs, a "**V**" if it's for vision care, or an "**S**" if it is for supplementary health (paramedical practitioner, equipment and appliance expenses).

Patient's Full Name	Type of claim D / V / S	Date of Receipt (yyyy-mm-dd)	Amount Claimed

☐ Did not rent equipment		
☐ Rented equipment	From (yyyy-mm-dd)	To (yyyy-mm-dd)
☐ Returned equipment	Date (yyyy-mm-dd)	

Is this claim related to a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No

If the answer is "No":
I acknowledge that the foregoing true to the best of my knowledge and my claim for benefits may be subject to an audit requiring proof from my doctor confirming my claim is not related to a MVA (Motor Vehicle Accident).
Initial Box ☐

Do you want any unpaid balance from this claim reimbursed from your Health Care Spending Account (if eligible)? ☐ Yes ☐ No

D Plan Member's signature

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By signing below,

- I solemnly declare that the information provided on this form is accurate to the best of my knowledge.
- I authorize IUOE Local 793, OEBAC, and any of its service providers to use and disclose the provided information and any other information collected about me, my Dependants, or my Beneficiaries to process my benefits, to obtain advice, and to manage the Health and Welfare, Group Legal, and Pension Benefits Plans.

Name of Plan Member	Signature of Plan Member	Date (yyyy-mm-dd)

Staple this form and all the attachments and mail them to

OEBAC
2201 Speers Rd., Unit 1
Oakville, ON L6L 2X9

or

Scan this form and the requested attachments (both sides if required) and email to
info@oebac.org