TEAMSTERS CANADA RAIL CONFERENCE

STATEMENT OF COVERED EXPENSES FOR SUPPLEMENTARY HEALTH BENEFITS

TO BE COMPLETED BY MEMBER:

Email your receipt and this form to the email address below.

Please indicate your employer group: CPKC Running Trades ☐ CPKC RTC ☐ CN Running Trades ☐

MEMBER'S NAME	SOCIAL INSURANCE NUMBER	EMPLOYEE NUMBER	DATE OF BIRTH Day Month Year	GENDER

MEMBER'S ADDRESS
NO. AND STREET CITY PROVINCE POSTAL CODE

Are health benefits payable from another group plan? Yes ☐ No ☐

If 'yes', policy number _____ And name of insurer _____

If coordination of benefits no longer applied - termination date _____

If 'yes' and claim is for a dependent child, please indicate spouse's date of birth _____

If child, indicate ☐ Student Date enrolled _____

Please provide a copy of current school year registration. Day Month Year

	FIRST NAME	GENDER	BIRTHDATE D M Y	DATE of EXPENSE D M Y	DRUG: NAME / D.I.N. OTHER: TYPE OF EXPENSE	AMOUNT CLAIMED
MEMBER						
SPOUSE						
CHILDREN						

I CERTIFY THAT THE ABOVE STATEMENT AND ATTACHEMENTS ARE COMPLETE AND CORRECT. I HEREBY AUTHORIZE THE RELEASE TO CANADIAN BENEFITS, OF ANY INFORMATION REQUESTED IN RESPECT OF THIS CLAIM. CANADIAN BENEFITS MAY USE MY SOCIAL INSURANCE NUMBER, IF PROVIDED ABOVE, FOR ALL CLAIM RELATED PURPOSES.

DATED: DAY:_____ MONTH _____ YEAR _____ MEMBER'S SIGNATURE: _____

Please submit claims to:
Administrator: info@canben.com

Canadian Benefits CONSULTING GROUP