D.A. Townley

4250 CANADA WAY, BURNABY, BC V5G 4W6
TEL: (604) 299-7482 FAX: (604) 299-8136
TOLL-FREE: 1-800-663-1356 www.datownley.com

EXTENDED HEALTH BENEFITS CLAIM

Policy No.	I.D./Certificate Number	
Member Last Name	First Name	
Member Address	City	Postal Code
Name of Employer or Union Affiliation		

Complete form, attach receipts and forward to:
D.A. TOWNLEY
4250 Canada Way, Burnaby, B.C. V5G 4W6
or submit by Fax: (604) 299-8136
or Email: health@datownley.com
Direct Deposit is now available
Contact the Administrator for details

PharmaCare Registration No.

LIST EXPENSES BELOW, GROUPED BY INSURED PERSON, IN DATE ORDER

Please include all applicable receipts. In case of dual coverage, send Statement of Payment from primary insurer along with photocopies of original receipts.

***PLEASE NOTE: Receipts will not be returned. Please retain copy if required.**

Name (Employee or Insured Dependent)	Relationship to Employee	Birth Date yr/mo/day	Date of Purchase yr/mo/day	Drug/Service Provided	Prescription DIN	Amount Charged

Additional space on reverse

NOTE: Birthdate for all dependents (spouse & children) must be given.
If dependent is age 21 or older, indicate school he/she is attending.

School: _____

☐ Full Time ☐ Part Time

Are any benefits or services provided under any other insurance or supplementary health plan? ☐ ***YES*** ☐ ***NO***

If "Yes", indicate:

Policy No.: _____ **Name of insuring agency:** _____

Name of Insured: _____ **I.D./Certificate Number:** _____ **Date of Birth** (y/m/d): _____

Are any of the above expenses the result of a motor vehicle accident/Workers Compensation claim? ☐ ***YES*** ☐ ***NO***

If "Yes", please specify and explain:

I understand that D.A. Townley collects personal information to assess eligibility for benefits; to determine and adjudicate benefits, to determine the cost and financially manage these benefits, as well as to meet regulatory or contractual requirements relating to such benefits and related services provided. I authorize the release of the information provided on or attached to this form for claims adjudication purposes and statistical analysis.

*Member Signature: _____ Date: _____

Name (Employee or Insured Dependent)	Relationship to Employee	Birth Date yr/mo/day	Date of Purchase yr/mo/day	Drug/Service Provided	Prescription DIN	Amount Charged

Please complete the reverse side of this form IN FULL and send together with all applicable receipts to:

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