D.A. TOWNLEY & ASSOCIATES LTD.
101 - 4190 LOUGHEED HWY., BURNABY, BC V5C 6A8
TEL: (604) 299-7482 FAX: (604) 299-8136
TOLL-FREE: 1-800-663-1356 www.datownley.com

FOR OFFICE USE ONLY

Registration No.

EXTENDED HEALTH BENEFITS CLAIM

Policy No.	Social Insurance Number	
Member Last Name	First Name	
Member Address	City	Postal Code
Name of Employer or Union Affiliation		

When accumulated receipts exceed the deductible, complete form, attach receipts and forward to:
D.A. Townley & Associates Ltd.
101 - 4190 Lougheed Hwy, Burnaby, BC V5C 6A8
Please submit receipts on a regular basis to avoid delay in processing.

PHARMACARE REGISTRATION #

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

We require original receipts. In case of dual coverage, send Statement Of Payment from prime 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: _____ **Social Insurance Number:** _____ **Date of Birth** (y/m/d): _____

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

If "Yes", please specify and explain:

I understand that D.A. Townley & Associates Ltd. 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: _____

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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 original receipts to:

D.A. TOWNLEY & ASSOCIATES LTD.

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Burnaby BC V5C 6A8
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