THE PBAS GROUP

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ASSIGNMENT OF BENEFITS FORM

THIS FORM IS AN ASSIGNMENT OF BENEFITS FORM, ALL PAYMENTS ARE MADE TO THE PROVIDER NOTED BELOW ON THE MEMBERS BEHALF.

Provider Name			Telephone Number
Mailing Address No. And Street	**City**	**Province**	**Postal Code**

TO BE CONSIDERED AN ELIGIBLE EXPENSE, CLAIMS MUST BE RECEIVED WITHIN EIGHTEEN (18) MONTHS FROM THE DATE EXPENSE WAS INCURRED USING THE DATE OF SERVICE OR THE DATE SUPPLIES WERE PURCHASED. THIS FORM MUST BE COMPLETED IN FULL AND SIGNED BY THE MEMBER.

Plan Name				Policy Number	Member Certificate
Insulators Local 110 Benefit Plan				110	
Member Name	**Date of Birth**			**Email Address**	
	D	M	Y		

Patient Information

Patient Name (if different than above)	Date of Service D	M	Y	Service Provided	Member Approval (Please initial)	Amount Charged

PLEASE ATTACH INVOICE AND DOCTOR REFERRALS, IF APPLICABLE. PHOTOCOPIES ARE ACCEPTED. **Total Charged:** ______

In signing this Assignment of Benefits Form, I hereby authorize PBAS to pay the above noted provider directly on my behalf for any expenses noted above and I certify that the charges for the medical supplies or services which the invoices are attached were incurred by myself or one of my eligible dependants upon recommendation and approval of the attending physician (if required under the terms of the Plan Text or where applicable) and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my eligible dependant.

AUTHORIZATION: On behalf of myself and my eligible dependants, I authorize the Insulators Local 110 Benefit Plan and group benefit provider, PBAS and any of its affiliates or re-insurers to exchange the personal information contained on this form or any other benefit related personal information contained in their files now or in the future respecting me or any of my eligible dependants. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as I and my dependants are covered by, or are claiming benefits under the present group contract, or any modification, renewal or reinstatement thereof. I further agree that a photocopy or electronic copy of this authorization is as valid as the original.

Date	Signature of Member	Telephone Number