FORM 09

Prescription Drug Claim

Please complete all information requested below, sign and return to Actra Fraternal Benefit Society (AFBS).

AFBS: 1000 Yonge Street
Toronto, ON M4W 2K2
PHONE: 416.967.6600 1.800.387.8897
FAX: 416.967.4744 1.888.804.8929
EMAIL: info@afbs.ca **WEB:** afbs.ca

AFBS WEST: 300 - 380 2nd Avenue West
Vancouver, BC V5Y 1C8
PHONE: 604.801.6550 1.866.801.6550
FAX: 604.801.6580
EMAIL: afbswest@afbs.ca **WEB:** afbs.ca

INSTRUCTIONS – How to File Your Claim

Reset Form

- For use when submitting Prescription Drug claims only
- Complete *SECTIONS 1, 2 & 3*
- Sign and date *SECTION 4*

SECTION 1 – Member Information *(please print)*

Member Name (Last, First, Middle Initial)

Date of Birth DD MM YYYY

Your AFBS Account Number 4501 ☐☐☐☐☐☐

ACTRA/WGC Number (if applicable)

I participate in the following program (check one)

☐ Members' Insurance Program ☐ Employer Benefits Program ☐ Writers' Coalition Program ☐ Arts & Entertainment Plan®

☐ Other _____

SECTION 2 – Claim Details *(please print)*

Insured Code: Member = **00** Spouse/Partner = **01** Dependant = **02**

The information on this form may refer to multiple expenses or insured family members. To save time, you can enter " (the ditto mark) to indicate when information is the same as the line above.

The Insured Code allows for quicker processing. See the *SECTION 2* heading above for explanation of Insured Codes.

Insured Code	Insured's Full Name	Date of Birth	Drug Ident.#	Qty.	Prescription #	Dispensing Fee	Dispensing Date	Submitted Amount
		DD MM YYYY					DD MM YYYY	
		DD MM YYYY					DD MM YYYY	
		DD MM YYYY					DD MM YYYY	
		DD MM YYYY					DD MM YYYY	
		DD MM YYYY					DD MM YYYY	
		DD MM YYYY					DD MM YYYY	
		DD MM YYYY					DD MM YYYY	
		DD MM YYYY					DD MM YYYY	

TOTAL

Attach Official, Original Receipts

Copies of receipts are accepted for Coordination of Benefits only.

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SECTION 3 – Co-ordinating with Other Insurers (Please include copies of receipts and Explanation of Benefits (EOB) from other insurance company.)

Are you or your spouse/partner or dependants covered under any other plan for the expenses being claimed?

☐ YES ☐ NO IF YES: ☐ My spouse only ☐ All dependants ☐ Myself only IF YES, please provide the following information:

Name of Insured Under the Other Plan (Last, First, Middle Initial)	Date of Birth DD MM YYYY

Name of Other Insurance Company

Plan/Policy Number	Certificate/Identification Number	Effective Date DD MM YYYY

SECTION 4 – Authorization

I understand that Actra Fraternal Benefit Society (AFBS) may check the accuracy of the information given in support of my claim.

I certify that all goods and services being claimed have been received by me or my insured dependants, and that the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan.

I certify that I am authorized to disclose and receive information about my spouse and/or dependants for purposes of assessing and paying a benefit if any and that any reimbursement will be paid to me.

I authorize AFBS, its agents and service providers to use and exchange information about me or my insured dependants needed for underwriting, administration and adjudicating of claims under this program with any other person or organization who has relevant information pertaining to this claim including health professionals, service providers, institutions, investigative agencies, insurers and reinsurers. I understand that information pertaining to this claim may be reviewed in event this program is audited.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Member's Signature (required)	Date DD MM YYYY

AFBS is committed to protecting the confidentiality of the personal information we collect from you and will use this information to assess your claim and administer the insurance program.

IF YOU HAVE MOVED OR ARE PLANNING TO MOVE, PLEASE NOTIFY AFBS.
ANY REIMBURSEMENT WILL BE SENT TO THE ADDRESS ON FILE.