



CARPENTRY WORKERS' BENEFIT PLAN OF BC

#300 – 2806 Kingsway, Vancouver, BC V5R 5V1
 phone (604) 438-2434 toll free 1-877-411-2806 fax (604) 438-5348 website cwbp.ca

DENTAL / OPTICAL / HEARING AIDS CLAIM FORM

MEMBER NAME	MEMBER NUMBER
ADDRESS	
CITY / PROVINCE	POSTAL CODE
AREA CODE	PHONE NUMBER

Name of Person Receiving Treatment	Dependent Number	Age	Date Service Performed	Total Expense	Co-insurance reimbursed	Recognized Amount <i>(OFFICE USE ONLY)</i>
TOTAL						
						Date
						Adjudicator

1. Is the treatment a result of an accident involving a third party (i.e. ICBC claim) ? Y ____ N ____

2. Are you and/or your dependents claiming reimbursement for any dental or optical expenses through another Plan? Y ____ N ____

 Name of other insurance carrier

 Group Number ID Number

DOCUMENTS REQUIRED TO MAKE A CLAIM:

- STANDARD DENTAL CLAIM FORM if expense is dental
- ORIGINAL PAID RECEIPT
- EXPLANATION OF BENEFITS statement from the primary carrier if CWBP is secondary carrier

PLEASE NOTE: ORIGINAL RECEIPTS WILL NOT BE RETURNED. Please take photocopies of all receipts before submitting to CWBP. If you will later be submitting these expenses to another carrier, they will require the Explanation of Benefits statement attached to your reimbursement cheque.
 Be sure to retain it for income tax purposes.

I hereby certify that the above listed expenses were incurred by me or my dependents on the dates shown and that the information and amounts are correct. I understand that the Carpentry Workers' Benefit Plan of BC is a reimbursement program and I am not submitting for any amounts I have not paid for in full.

MEMBER'S SIGNATURE _____ DATE _____

MEMBER INFORMATION

Dental, Optical, & Hearing Aid reimbursement is based on the date of service, not the date of payment.

A member must be covered on the date the services were performed and have a remaining balance in his/her Dental/Optical account.

- **ORIGINAL PAID RECEIPTS MUST BE SUBMITTED WITH YOUR CLAIM.**
- **TOTAL FEES MUST BE PAID IN FULL – PARTIAL PAYMENTS WILL NOT BE REIMBURSED.**

DENTAL / OPTICAL BENEFIT effective July 1 2008:

1. All normal dental services are covered at 80% up to the member's maximum allowable. **It is the member's responsibility to know how much he/she is eligible to claim.**
2. The yearly dental / optical balance of \$4,000.00 (effective July 1 2008) is pro-rated from January throughout the remainder of the year for new members. If a member's coverage is effective:

Coverage date		Pro-rated maximum	Coverage date		Pro-rated maximum
January 1 st	=	\$4,000.00	July 1 st	=	\$1,999.98
February 1 st	=	\$3,666.63	August 1 st	=	\$1,666.65
March 1 st	=	\$3,333.30	September 1 st	=	\$1,333.32
April 1 st	=	\$2,999.97	October 1 st	=	\$ 999.99
May 1 st	=	\$2,666.64	November 1 st	=	\$ 666.66
June 1 st	=	\$2,333.31	December 1 st	=	\$ 333.33

3. If a member has two insurance carriers, the maximum reimbursable amount for that member is 80% of the above listed amounts, not 100%. Note: If the other insurance plan is reimbursing a portion of an eligible expense, the member will receive 100% of the difference. However, if the other insurance plan is not reimbursing a portion of an eligible expense, the member will receive 80% reimbursement, not 100%.

ORTHODONTICS:

- A copy of the orthodontic contract is required with the first orthodontic claim.
- **NOTE:** CWBP pays as per the orthodontic contract and claims must be made accordingly. CWBP does not reimburse for orthodontic treatments paid in advance for services not yet provided.

OPTICAL BENEFIT:

1. Optical Exams are reimbursed at 80% (not part of the \$500.00 optical limit) and are limited to one exam for each covered dependent per year (rolling period).
2. Effective July 1 2008, the total allotment for optical expenses is **\$500.00** per dependent per yearly rolling period. The rolling period starts from the last date of purchase.(i.e. If the date of purchase is October 15 2008, the dependent would not be eligible for another \$500.00 until October 16 2009.) The maximum reimbursement amount for all optical expenses is **\$400.00** (80% of \$500.00).
3. Includes prescription lenses, frames, contact lenses, repairs and laser eye surgery.

Exclusions: fitting fees, optical lens insurance/warranty, non-prescription lenses, magnifiers purchased over the counter, sunglass clipons, cleansing products, safety cords, and any taxable items

HEARING AID BENEFIT:

1. Includes repairs and batteries. The maximum allowable is \$800.00, reimbursed at 80% in a five-year rolling period. The rolling period starts from the last date of service, and is not combined with the dental / optical balance.

Exclusions: ear plugs, hearing tests and any products covered through Workers' Compensation Board.

**ALL DENTAL / OPTICAL / HEARING AID CLAIMS FOR THE PREVIOUS YEAR
MUST BE RECEIVED IN THE PLAN OFFICE BY JUNE 30TH.
THERE WILL BE NO EXCEPTIONS AFTER THE DEADLINE.**