



# EXTENDED HEALTH CARE PLAN TRAVEL & ACCOMMODATION OPTION

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Burnaby, BC

Please type or print in ink.

Please refer to your Pacific Blue Cross identity card for your group, social insurance and dependent numbers

Group number	Social Insurance Number	Dep. no.	Patient's surname	First name	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Previous coverage numbers		Nature of illness				

Date/dates in attendance \_\_\_\_\_

Is it necessary for the patient to be accompanied by an attendant?  Yes  No

Will further referrals be required?  Yes  No

### A. Referral to Medical Specialist (to be completed by the referring physician)

Name of Referring Physician	Referred to (Name of Medical Specialist)		
Location	Referral Date	Appointment Date	
Reason for Referral	Physician/Surgeon Signature		Date
* If there is more than two months between referral date, please explain why?			

### B. Claim for Travel Expenses - (to be completed by employee)

From	To	Standard amount to be claimed

### C. Claim for Accommodation Expenses - (itemized receipts must be submitted)

Name of accommodation	Location	Number of days claimed	Amount paid

Member's name ( please print )		
Home address ( Number & Street )		
City or town	Province	Postal code

\_\_\_\_\_  
Member's signature

\_\_\_\_\_  
Date of application

For PBC use only - do not write in this space			
Effective			E.H.O.

\_\_\_\_\_  
Signature of company representative