



**EXTENDED HEALTH CARE PLAN  
TRAVEL & ACCOMMODATION OPTION**

Mailing Address:  
P.O. Box 7000  
Vancouver BC V6B 4E1  
Telephone 604.419-2800  
Fax 604.419-2601

Street Address:  
4250 Canada Way  
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

<b>For PBC use only - do not write in this space</b>			
Effective			E.H.O.
Member's name ( please print )			
Home address ( Number & Street )			
City or town	Province	Postal code	

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

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

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