Capri Townley
BENEFIT ADMINISTRATORS INC.
SUITE 100 - 1500 HARDY STREET, KELOWNA, BC V1Y 8H2
PHONE: 250-860-2426 TOLL FREE: 1-888-651-1497
Fax: 250-860-1213

FOR OFFICE USE ONLY

Reference No.

When accumulated receipts exceed the deductible, complete form, attach receipts and forward to:
Capri Townley Benefit Administrators Inc.
Suite 100 - 1500 Hardy Street,
Kelowna, B.C. V1Y 8H2
Please submit receipts on a regular basis to avoid delay in processing.

PHARMACARE REGISTRATION #

Group No. _____ Social Insurance Number _____

Member Last Name _____ First Name _____

Member Address _____

Name of Employer _____

Daytime Phone Number Where You Can Be Reached (____) _____

LIST EXPENSES BELOW, GROUPED BY INSURED PERSON, IN DATE ORDER

We require original receipts. In case of dual coverage, send Statement Of Payment from prime insurer along with photocopies of original receipts.

***PLEASE NOTE: Receipts will not be returned. Please retain copy if required.**

Name (Employee or Insured Dependent)	Relationship to Employee	Birthdate yr/mo/day	Date of Service yr/mo/day	Drug/Service Provided	Prescription DIN	Amount Charged
						$

NOTE: Birthdate for all dependents (spouse & children) must be given.
If dependent is age 21 or older,
indicate school he/she is attending.

Additional space on reverse

School: _____

_____ Full time _____ Part Time

Are any benefits or services provided under any other insurance or supplementary health plan? ☐ ***YES*** ☐ ***NO***
If "Yes", indicate:

Policy No.: _____ **Name of insuring agency:** _____

Name of Insured: _____ **Social Insurance Number:** _____ **Date of Birth** (y/m/d): _____

Are any of the above expenses the result of a motor vehicle accident/WCB claim? ☐ ***YES*** ☐ ***NO***

If "Yes", please specify and explain:

I understand that Capri Townley Benefit Administrators Inc. collects personal information to assess eligibility for benefits: to determine and adjudicate benefits, to determine the cost and financially manage these benefits, as well as to meet regulatory or contractual requirements relating to such benefits and related services provided. I authorize the release of the information provided on or attached to this form for claims adjudication purposes and statistical analysis.

★Member Signature: _____ Date: _____

Name (Employee or Insured Dependent)	Relationship to Employee	Birthdate yr/mo/day	Date of Service yr/mo/day	Drug/Service Provided	Prescription DIN	Amount Charged
						$

Please complete the reverse side of this form IN FULL and send together with original receipts to:

CAPRI TOWNLEY BENEFIT ADMINISTRATORS INC.

Suite 100 - 1500 Hardy Street

Kelowna, B.C. V1Y 8H2

Tél: Sans frais 1-888-651-1497

Local: 250-860-2426