



BOILERMAKERS' NATIONAL HEALTH PLAN (CANADA) ANNUAL MEDICAL EXAM BENEFIT PHYSICIAN'S CONFIRMATION

Note: The Plan has agreed to pay the covered Plan member up to \$50.00 to provide this completed Form. Please complete all information and attach the receipt showing the fee you (the Member) paid the physician to complete this Form. Please note the Plan does not pay for the cost of the medical exam. The Plan does not/will not receive any personal information about your medical exam. The Plan only requires confirmation that you had a medical exam.

**Please print or complete the fillable form available online.
Reimbursement payments will be issued to the Member.
Please provide a copy of the physician's receipt.**

PHYSICIAN'S INFORMATION

PHYSICIAN'S NAME: _____
Last Name First Name

PHYSICIAN'S ADDRESS: _____
Suite/Apt. No. Street Number Street Name

City Province Postal Code

TELEPHONE NUMBER: () _____ - _____

PHYSICIAN'S CONFIRMATION

I, DR. _____ CONFIRM THAT THE FOLLOWING PLAN MEMBER _____
Physician's Name Plan Member Name

HOME ADDRESS: _____
Suite/Apt. No. Street Number Street Name

City Province Postal Code

HAS BEEN GIVEN AN ANNUAL MEDICAL EXAMINATION BY ME.

Signed: _____ (Physician's Signature)

Date: _____

Please mail or e-mail this form and the physician's receipt to the Plan Administration Office
45 McIntosh Drive, Markham, Ontario L3R 8C7, Telephone: (905) 946-2530 Toll Free: 1-800-668-7547 Fax: (905) 946-2535
E-mail: medical@boilermakersbenefits.ca

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