



## BENEFIT ENTITLEMENT REVIEW CONFIDENTIAL APPLICATION

PAGE 1 OF 3

### MEMBER'S NAME

First name

Last name

### DATE OF APPLICATION

DD/MM/YYYY

### CERTIFICATE NO.

123 4567 896 0

### ADDRESS

Address

City

Postal code

### TELEPHONE

(000) 000-0000

### EMAIL ADDRESS

exemple@exemple.com

**HAVE YOU SPOKEN WITH A CLAIMS SPECIALIST AT JOHNSON INC?**

**PLEASE PROVIDE**

**YES**

Name of the person

Date of the call DD/MM/YYYY

**NO**

If you have not yet spoken with a Claims Specialist regarding your claim, please do so prior to submitting your application. They may be reached, toll-free, at: 1-800-442-4428 or at 506-454-4654 (Fredericton area).

**WHICH NBTF GROUP INSURANCE PLAN OPTION DOES YOUR CLAIM ORIGINATE FROM?**

**EXTENDED HEALTH CARE**

**DENTAL**

**TRAVEL INSURANCE  
(ALLIANZ GLOBAL ASSISTANCE)**

**OTHER**

**PLEASE EXPLAIN BRIEFLY, IN THE SPACE PROVIDED, THE NATURE OF YOUR CLAIM, WHY IT WAS NOT REIMBURSED, AND THE REASONS FOR APPEALING THE DECISION:**

**YOUR COMPLETED APPLICATION SHOULD INCLUDE THE FOLLOWING:**

- Signed Benefit Entitlement Review Application
- Completed Claims Form
- Original receipts
- Copy of any correspondence from Johnson Inc. concerning this claim

**PLEASE SEND COMPLETED FORM TO:**

Co-Chairs  
NBTF Group Insurance Plan  
650 Montgomery  
Fredericton, NB E3B 5G2

**AUTORISATION**

I consent to the collection, use and disclosure of all information required by NBTF Group Insurance Plan Johnson Inc., Manulife Financial and/or Allianz Global Assistance to process this application.

This information will be held in strict confidence.

**NAME (PLEASE PRINT)**

First name

Last name

**SIGNATURE**

**DATE**

DD/MM/YYYY