



BENEFIT ENTITLEMENT REVIEW CONFIDENTIAL APPLICATION

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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

example@example.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 Street
Fredericton, NB E3B 5G2

AUTHORIZATION

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