SEAFARERS' MEDICAL PLAN
1333 ST.JACQUES - 2nd FLOOR
MONTREAL QC H3C 4K2
TEL.: (514) 931-7859 FAX: (514) 931-3667

APPLICATION FOR REIMBURSEMENT OF PRESCRIBED MEDICATION AND INJECTIONS

Kindly complete this form in full and attach your original receipts which will be returned.

Name of Seafarer	Union No.	Social Insurance No.	Name of Employer Company	Name of Last Ship

Address	Apt.	City	Prov.	Postal Code	Telephone No. ( ) -

Patient's First Name	Patient's Birth Date	Relationship	Name of Pharmacy	Date of Purchase	D.I.N.	Name of Medication	Prescribed Dosage (ex: 1 tablet twice daily)	Amount Paid
	D | M | Y			D | M | Y				
	D | M | Y			D | M | Y				
	D | M | Y			D | M | Y				
	D | M | Y			D | M | Y				
	D | M | Y			D | M | Y				
	D | M | Y			D | M | Y				
	D | M | Y			D | M | Y				
	D | M | Y			D | M | Y				
	D | M | Y			D | M | Y				
	D | M | Y			D | M | Y				
	D | M | Y			D | M | Y				
	D | M | Y			D | M | Y				
	D | M | Y			D | M | Y				

Is the seafarer's spouse also a seafarer? YES ☐ NO ☐ Is the seafarer's spouse covered by any other insurance for medication and injections? YES ☐ NO ☐

I hereby certify that all the above information is true and that the documents submitted herewith are authentic. Should any of the same documents submitted on my behalf be found to have been falsified, I will be liable to suspension of further benefits.

Signature of Seafarer or Spouse: _____ Date: ____ / ____ / ____
Day Month Year