claimsecure

Health Services Spending Account Form

Member Information (Please Print)

Group #	Certificate #	Member Surname	First Name	Employer, Union, School Name
5667				

Member's Home Address	Apt #	Street # and Name	City	Province	Postal Code

Telephone Number : ( ) Work ( )

COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENTS

Dependent's name (Last, First)	Date of Birth (day/month/year)	Relationship to Plan Member
		Spouse ☐ Daughter ☐ Son ☐ Other ☐ (describe)
		Spouse ☐ Daughter ☐ Son ☐ Other ☐ (describe)

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member. I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.

Health Services Spending Account Signature

I wish any portion of my claim not paid by my Extended Health or Dental plan to be reimbursed from my *Health Services Spending Account.*

I hereby certify that the above expenses are considered eligible by Revenue Canada to be payable from a *Health Services Spending Account*

Signature _____ **Date** _____

EXPENSES– (Attach original receipts and list below)

Nature of expense	Date incurred (dd/mm/yyyy)		Amount

Total Claim $ 0.00

1. Are any health benefits or services provided under any other group insurance or health plan, Worker's Compensation or government plan? ☐ Yes ☐ No

2 a. If yes, indicate member under other plan: ☐ Self ☐ Spouse

Name _____ Date of Birth ___ Day ___ Month ___ Year

2 b. Name of other insuring agency or plan _____

Policy No. _____ Certificate No. _____

N.B. For coordination of benefits, children must claim under the plan of the parent with the earlier month and day of birth in the calendar year.

All information recorded on this form is confidential.
Send all claims and inquiries to:

CLAIMSECURE INC.
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