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According to your plan, please submit the completed form to:

Quebec
 Group Health and Dental Claims
 PO Box 800, Station Maison de la Poste
 Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
 Group Health and Dental Claims
 PO Box 4643, Station A
 Toronto, Ontario M5W 5E3

CLAIM FORM

Medical Expenses – HSA

Please print in ink and sign.
MEMBER INFORMATION

 Policyholder's name _____ **Policy no.**

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Member's last name _____ First name _____

 Certificate no. _____ Date of birth

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 Sex: Male Female
 Language: English French

1. COORDINATION OF BENEFITS

Under the coordination of benefits section of your plan, if one of your dependents is covered under a medical expense benefit, the expenses incurred by your dependent must first be submitted to his or her insurer. You may subsequently submit a claim for the balance, if applicable, under your plan.

The expenses incurred by insured dependent children must be submitted to the plan of the parent whose birthday comes first during a calendar year.

Are you or your dependents, covered by another group plan? No Yes **If yes, specify:**

Name of insurance company _____ Policy no. _____

 Health Coverage: Individual Family

 Name of Spouse _____ Date of birth

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2. MEDICAL EXPENSES (Attach the original invoices and keep a copy for the coordination of benefits and income taxes.)
***Health Spending Account (HSA)**

 Do you wish the unpaid portion of any expense provided for under the group policy to be paid under your HSA? Yes No

If yes, please indicate which expenses you wish to have the unpaid portion paid under your HSA. Please indicate the applicable expenses by checking off the box in the HSA column.

All healthcare expenses which are not provided for under your group policy may be paid under your HSA.

Note: If the person for whom the claim is applicable has coverage elsewhere, you must first submit the expenses to the other carrier before requesting payment under your HSA.

Name (Member or insured dependent)	Relationship to member	Date of birth			Handicapped child	Children 18 and over		Amount	HSA*
		Y	M	D		Full-time student	Name of school		
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	<input type="checkbox"/>
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	<input type="checkbox"/>
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	<input type="checkbox"/>
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	<input type="checkbox"/>
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	<input type="checkbox"/>
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	<input type="checkbox"/>
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	<input type="checkbox"/>
Total								\$	

If there are expenses for the rental or purchase of an appliance, please attach a letter from your physician describing the diagnosis.

 If the claim is the result of an accident, specify type of accident: Work Motor vehicle Crime victim Other _____

 Date of accident

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 Place of accident _____

CONTINUED ON THE NEXT PAGE

