Health Services Spending Account Form

Member Information (Please Print)

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

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

Telephone Number: ( )	Work: ( )	Email

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. If I am submitting personal information about myself and/or my spouse and/or dependents, I acknowledge that I/he/she/we/they have reviewed and consent to the Disclaimer and Privacy Policy (https://www.claimsecure.com/privacy/). 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. I understand and agree that ClaimSecure will conduct audits of claims submitted by me for purposes including, but not limited to, preventing and detecting fraud. I authorize ClaimSecure, and persons acting for ClaimSecure, to disclose this claim, or any personal information contained in this claim, to the benefit plan sponsor/employer for the purposes of reporting fraud suspicious claims. I am aware that under certain circumstances permitted by law, ClaimSecure, or persons acting on its behalf, may be required or permitted to disclose this claim, and the information contained in this claim, including personal information, to others without my knowledge or consent, or the consent of the individual to whom the information relates. In all other circumstances, ClaimSecure will only disclose such personal information in accordance with ClaimSecure's Privacy Policy (https://www.claimsecure.com/privacy/). We may revise this Disclaimer from time to time, and will post the most current version on our website at (https://www.claimsecure.com). Please check back from time to time to ensure that you are aware of any changes and are using the most recent version of the Disclaimer. Your continued use of our services after any such changes constitutes your acceptance of the Disclaimer as revised.

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

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

Total Claim $ 0.00

*** Note: Do NOT staple or tape receipts to the claim form ***

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

CLAIMSECURE INC.
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service@claimsecure.com