



# HEALTH CARE SPENDING ACCOUNT (HCSA) CLAIM AND PAYMENT REQUEST FORM

Use this form to submit expenses to your Health Care Spending Account

- A Health Care Spending Account may be used to claim health or dental related costs incurred by you and/or your dependents. These expenses must meet the Canada Revenue Agency's (CRA) tax deduction guidelines for eligible expenses.
- It is your responsibility to determine if your medical expenses are allowable under the Canada Revenue Agency's rules and guidelines.

## 1. PLAN MEMBER INFORMATION

Surname		First Name	Alberta Blue Cross ID Number
Address			Group Number <b>35</b>
City	Province	Postal Code	Telephone Number

## 2. PLAN CHOICE

The intent of this claim form is to submit expenses directly to your HCSA plan. If you would like Alberta Blue Cross to determine if the expenses below could be paid through your health/dental plan first before being sent to your HCSA plan, please check the box below:

Please pay eligible amounts through my health/dental plan first.

## 3. CLAIM SUBMISSION DETAILS: (Remember to attach supporting receipts and/or statements from other benefits carriers.)

Expense Description	Date of Service (YY / MM / DD)	First Name / Last Name (if different than Plan Member)	Relationship to Employee	Amount Claimed
MAJOR MEDICAL PREMIUMS				ENTER TOTAL AMOUNT
DENTAL PREMIUMS				ENTER TOTAL AMOUNT

(NOTE: If additional space is required please fill out an additional claim form.)

Total Claim: \$

## 4. PAYMENT REQUEST

- Please reimburse for the attached Expenses. → (FOR PREMIUMS PAID IN 2007)
- Please issue payment for all Expenses held in my Health Care Spending Account, including the attached Expenses.
- I do not wish to be reimbursed at this time.

## 5. EMPLOYEE CONSENT AND DECLARATION

I certify that the information contained in this and other documents supporting this claim is complete and true. By submitting this form, I understand that I am requesting payment be made for the above expenses, in accordance with my Health Care Spending Account plan. I accept full responsibility to ensure that all expenses incurred and submitted for payment from my Health Care Spending Account plan are allowable medical expenses as defined under the *Income Tax Act*. If unsure please visit Canada Revenue Agency's (CRA) web site and/or call 1-800-959-8281 to obtain an official ruling.

I understand that the personal information provided herein, as well as any other personal information currently held by Alberta Blue Cross about me and eligible dependents will be used to determine eligibility for this benefit, verify, assess and pay claims, and administer my Health Care Spending Account plan. I certify that I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I hereby acknowledge and agree that the personal information may be exchanged between Alberta Blue Cross and a health care professional, practitioner, institution or health benefits provider or insurer when needed for a purpose stated above.

I understand that my personal information will be kept confidential and secure.

I certify that the individuals for whom this claim is made are eligible under my Health Care Spending Account plan.

Signature of Plan Member (required)

Date

This consent is obtained in accordance with Alberta's Health Information Act, of Alberta's Personal Information Protection Act and the federal Personal Information Protection and Electronic Documents Act.

Complete this form, attach your original receipts, sign and send to:

Alberta Blue Cross, 10009 - 108 Street NW, Edmonton, AB T5J 3C5

If you have any questions, please contact Customer Services at 1-800-661-6995.

\* ATTACH A COPY OF YOUR PAY STUB (PAY PERIOD # 25) AND HIGHLIGHT THE MAJOR MEDICAL & DENTAL PREMIUMS

LEAVE BLANK

CHECK THIS BOX

SIGN AND DATE

ENTER THE TOTAL AMOUNT OF BOTH PREMIUMS