HEALTH CARE SPENDING ACCOUNT CLAIM FORM

Your Health Spending Account is debited for each claim payment processed.
We encourage you to batch claims to reduce costs.

EMPLOYEE STATEMENT

Employer	Date of Birth	Male o Female o	Group #	Certificate #
Employee Name	Employee Address (Street, Province and Postal Code)			

TOTAL EACH TYPE OF EXPENSE FOR EACH CLAIMANT ON A SEPARATE LINE

Attach receipt for each expense listed
Original receipts only (photocopies or carbon copies are not acceptable)

Claimant's First Name	Relationship	Date of Birth Day	Mo.	Yr.	Type of Expense i.e. Drugs, Vision, Practitioner, etc.	Date Expense Was Incurred	Total Amount Charged
(It is recommended that you accumulate at least $100 in total expenses before submitting HSA claims) **TOTAL**							

Falsifying or tampering with claim documents / receipts could have legal consequences

Authorization:

I certify that the expenses listed above and for which the original receipts are attached were incurred by myself or by my eligible dependent(s). The expenses were incurred upon the recommendation and approval of the attending physician (where required by this policy/plan) and were required medical treatment. I declare that the statements made on this form are complete and true.

I understand that the information provided by me to RWAM Insurance Administrators Inc. ('RWAM') in connection with this claim and any of my relevant related claims will be used for the purposes of validating my claim, determining my eligibility for the group insurance benefits claimed under my plan, administering my claim and processing my claim according to the results of the adjudication. I hereby authorize the release to RWAM of any information requested by RWAM for these purposes. I also understand and authorize that, for the purposes stated, the information gathered by RWAM may be accessible to and/or exchanged with the insurer/provider, any participating reinsurer(s), any hospitals, any health care providers [i.e. including but not limited to physiotherapists, chiropractors, pharmacists, registered massage therapists, physicians, dentists], any other parties named on receipts submitted to RWAM in connection with my claim, investigative organizations, and any relevant third parties retained by RWAM. If I am claiming for my eligible dependent spouse/child, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and exchange of their personal information for the same purposes. This authorization shall remain valid for as long as I am claiming benefits or service, or revoked in writing by myself.

A photocopy or facsimile transmission of this authorization shall be considered as valid as the original.

_____	r _____	( ) - _____
DATE	**SIGNATURE OF EMPLOYEE**	**TELEPHONE NO.**

This form must be completed in full. If not, the form will be returned to you which will delay the processing of the claim.

Mail completed form to: RWAM INSURANCE ADMINISTRATORS INC.
Attention: Health Claims Department
49 Industrial Drive, Elmira, Ontario N3B 3B1