

DATE

EXTENDED HEALTH CARE and HEALTH CARE SPENDING ACCOUNT CLAIM

EMPLOYEE STATEMENT								
Employer			D	ate of Birth	Male O Female O	Group &	Division #	Certificate #
Employee Name				Employee Address (Street, Province and Postal Code)				
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			L					
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)								acceptable)
Claimant's First Name	Relationship	Date of Birth Day Mo.	h Yr.	Type of Expense i.e. Drugs, Vision, Practitioner, etc.				Total Amount Charged
		Day Mo.		no. Drago, violo	in, i raditionor, did	•	vvac mounta	Onargou
		<u>.</u>						
(It is recommended that you accumulate at least \$30 in total expenses before submitting a claim) TOTAL								
Is this claim for a work related accident or sickness on yourself or your dependent(s)? Yes O No O If 'Yes', has a claim been submitted to WCB/WSIB? Yes O No O								
If this claim is for a dependent, is the dependent employed? Yes O No O If "Yes", indicate name and address of dependent's employer								
If 'Yes' Full-time O Part-time O								
Does the claimant have any other group health coverage? Yes O No O If 'Yes', indicate the name of the employer and the insurance company								
HEALTH CARE SPENDING ACCOUNT								
							Division #	Certificate #
 ○ No ○ Yes If 'Yes', complete the separate Group, Division & Certificate # assigned to your Health Care Spending Account 5 						'		
Falsifying or tampering with claim documents / receipts could have legal consequences								
Authorization:	ampenng with ciai	in documents /	/ receipt	is could have leg	jai consequence	55		
I certify that the expenses listed above and the	for which the origina	I receipts are att	tached w	ere incurred by my	self or by my elig	jible deper	ndent(s). The exp	enses were incurred
upon the recommendation and approval of t made on this form are complete and true.	the attending physic	ian (where requi	ired by th	nis policy/plan) and	d were required n	nedical tre	atment. I declare	that the statements
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.								
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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.

SIGNATURE OF EMPLOYEE

Attention: Health Claims Department
49 Industrial Drive, Elmira, Ontario N3B 3B1

TELEPHONE NO.