Clarica Life Insurance Company / Waterloo, Ontario

# Health Care Spending Account (HCSA) Claim Form

CLARICA™

## **Important** Please Read Carefully

You may pay less if you submit your health and dental expenses to all other insurance and benefit plans first, and then pay any unpaid portions of these expenses from your health care spending account (HCSA).

Please check the appropriate box below to choose how you want your expenses paid. We will process your claim based on your instructions on this claim form.

❑ **I want to submit my expenses to Clarica's health plan or dental plan first. I would like any unpaid portions of my expenses paid from my health care spending account.**

- Complete a standard Clarica health claim or dental claim form.
- Complete parts B and C of this form.
- Staple together all itemized original receipts, original statements, and claim forms.
- Mail to the applicable address on the standard Clarica health claim or dental claim form.

❑ **I do not want to submit my expenses to Clarica's health plan or dental plan. I would like the entire expense amount paid from my health care spending account.**

- Complete all parts of this form.
- Circle or highlight the expense and the amount to be paid on each **original** receipt or **original** statement.
- Staple all receipts and statements to this form.
- Mail to: CLARICA
  HEALTH AND DENTAL CLAIMS
  PO BOX 3417 STN D
  OTTAWA ON K1P 1G1

**Clarica will not return any receipts.**

## A. Health and Dental Expenses

| Patient's name (first and last) | Relationship to employee | Description of expense | Practitioner, dentist or supplier name | Date of visits or purchase DD | MM | YYYY | Amount to be reimbursed for each expense |
|---|---|---|---|---|---|---|---|
| | ❑ self ❑ spouse ❑ child ❑ other _____ | | | | | | $ |
| | ❑ self ❑ spouse ❑ child ❑ other _____ | | | | | | $ |
| | ❑ self ❑ spouse ❑ child ❑ other _____ | | | | | | $ |
| | ❑ self ❑ spouse ❑ child ❑ other _____ | | | | | | $ |
| | ❑ self ❑ spouse ❑ child ❑ other _____ | | | | | | $ |
| **Total of all health and dental expenses** → | | | | | | | **$** |

## B. Employee Information

Employee's name _____ (Last / First (in full))

Address _____ (Street/Apt.#/RR#)

Date of birth ___ ___ ___ (Day Month Year)

Sex ❑ Female ❑ Male

City _____ Province

Member ID _____

Policy/plan no. _____

Postal code _____ Phone no. ( )

## C. Authorization

I certify that the information given on this form is true, correct and complete to the best of my knowledge. I declare that the dependants for whom expenses are being submitted are dependent on me for maintenance or support as required by the Canada Customs and Revenue Agency or the Quebec Taxation Act. I authorize the release, by any health care provider, Clarica or any of its agents, of any information necessary for the administration of this claim or my group plan. A photostat of this authorization is as valid as the original.

**Employee's signature** ✗

Date ___ ___ ___ (Day Month Year)

3481-Bil.-5-01

The intentional falsification, misrepresentation or omission of information on or relating to this claim constitutes fraud.