MEDAVIE BLUE CROSS™

HEALTH SPENDING ACCOUNT (HSA) CLAIM FORM

MEMBER INFORMATION

ID Number: _____ Policy Number: _____ Date of Birth (DD/MM/YYYY) _____

Last Name: _____ First Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Telephone Number: _____ Work Telephone Number: _____

Has your mailing address changed since your last claim? ❑ Yes ❑ No If yes, signature of member is required for validation: _____

OTHER COVERAGE

Do you or any dependents have coverage under any other plan?

❑ **No** If applicable, please provide the Termination Date (dd/mm/yyyy): _____

❑ **Yes Complete the following:** Name of other Insurer: _____

Member Name: _____ ID Number: _____

Type of policy (✓): ❑ **Individual** ❑ **Group** Effective Date: _____ Policy Number: _____

Please indicate type of coverage (✓): ❑ Hospital ❑ Travel ❑ Extended Health ❑ Drugs ❑ Vision ❑ Dental ❑ **All**

CLAIM INFORMATION

Claimant's Name		**Relationship to Member** Self, Spouse, Child	**Date of Birth**			**Type of Service** E.g. Physiotherapy; diabetic supplies; eye glasses; etc.	**Date of Service**			**Amount Paid**	**Apply unpaid balance to HSA** (check for each expense)	
First Name	Last Name		day	month	year		day	month	year		YES	NO
										TOTAL CLAIM AMOUNT		

MEMBER STATEMENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me, and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the subscriber of any policy under which I am a participant and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.
I authorize my Blue Cross plans to collect, use and disclose my personal information as described above.

All medical expenses must be claimed through your provincial and group insurance plans before payment can be made from a Health Spending Account. I confirm that benefits under this plan, any government program or alternate group plan (I.e. spouse's/partner's coverage) have been accessed.

I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes. If claiming expenses for an uninsured dependent under your Health/Dental contract, I, the undersigned, accept full responsibility that this dependent qualifies under the Canadian Federal Income Tax Act as an eligible dependent.

MEMBER Signature: _____ Date _____

This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.

ADDRESSES

New Brunswick and Prince Edward Island
644 Main St PO Box 220
Moncton NB E1C 8L3
Inquiries: 1-800-667-4511

Nova Scotia
230 Brownlow Ave, Dartmouth
PO Box 2200 Halifax NS B3J 3C6
Inquiries: 1-800-667-4511

Newfoundland and Labrador
66 Kenmount Road, Suite 102
Kenmount Business Centre
St. John's NL A1B 3V7
Inquiries: 1-800-667-4511

Ontario
185 The West Mall Suite 1200
Etobicoke ON M9C 5P1
Inquiries: 1-800-355-9133

* **Please ensure all areas are complete.**
* **Please attach all original paid-in-full receipts; if receipts were submitted under another plan and the unpaid portion is now being claimed, please attach copies of your receipts along with the original "Explanation of Benefits" statement from the other insurer.**
* **Prescription drug receipts must indicate name; strength and quantity of drug; drug identification number (DIN); prescription number (RX); patient's name.**