Green Shield CANADA

Where quality is more than a claim

HEALTH CARE SPENDING ACCOUNT

CLAIM SUBMISSION FORM

This form should be used when claiming reimbursement under your* Health Care Spending Account, Health Care Expense Account or Health Services Spending Account *for eligible expenses which are not covered (or not covered in full) by your Health or Dental Plan.

Green Shield I.D. #	**Alternate I.D. #**	**Date of Birth** _____/_____/_____ YY MM DD
Surname	**First Name**	
Mailing Address		**Telephone #**
City	**Province** **Postal Code**	**( )**

Be sure you have first submitted these claims to any provincial health insurance, or any private health care plan you may have (including another Green Shield plan, spousal plan, etc.)

Are you claiming for the total expense?

☐ Yes, please process the following claim(s) under my Account.

☐ No, please co-ordinate with my and/or my spouse's Green Shield Plan. Other Green Shield I.D.#_____

HEALTH CARE EXPENSES (Please include receipts, prescriptions, etc.)

Description of Expense	Date of Expense	Name	Relationship to Employee Self or Dependent	Amount
			Total Amount Claimed	**$**

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate, to the best of my knowledge. I authorize Green Shield Canada to exchange information with other parties as required and only when the information is needed to administer this benefit claim and/or to confirm the accuracy of this information.

Mail this form and enclosures to: GREEN SHIELD CANADA
Attention: Health Care Spending Account
PO Box 1606, Windsor, Ontario N9A 6W1

For inquiries contact: CUSTOMER SERVICE CENTRE
Toll Free 1-888-711-1119 or 519-739-1133

Subject to the limitations of Revenue Canada and the rules and regulations of the plan, I hereby authorize Green Shield to charge the above claim to my Health Care Spending Account.

_____
Signature of Employee

The cost, if any, of obtaining this information is at the expense of the Patient/Subscriber.