# 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.***

| **WLI number** | **Alternate I.D. #** | **Date of Birth** |
|---|---|---|
| **Surname** | **First Name** | _____ / _____ / _____<br>YY MM DD |
| **Mailing Address** | | **Telephone No. ( )** |
| **City** **Province** **Postal Code** | | |

Do you have any other Group Insurance coverage that may include these services as benefits? Yes ☐ No ☐

If yes, please provide insurance company name_____

If other coverage is Wawanesa Life, indicate Wawanesa Life number_____

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

☐ want my eligible expenses paid from my Wawanesa Life health plan or dental plan **first** and any unpaid portions of my eligible expenses paid from my HCSA

☐ I want all my eligible expenses paid from my Wawanesa Life health plan or dental plan **first,** then any unpaid portions of my eligible expenses paid from my other Wawanesa Life #_____ and if still unpaid portion remaining, paid under my HCSA.

☐ I want all my eligible expenses paid directly from my HCSA.

**NOTE:** *If no box has been checked, we will pay claims according to Box 1.*

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

| Description of Expense | Date of Expense | Name | Dependent # | Amount |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | **Total Amount Claimed** | $ |

**I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.**

**By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. I understand that the information provided by me to Wawanesa Life about myself and my dependents, will be used by Wawanesa Life for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.**

**I further authorize Wawanesa Life to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.**

**Subject to the limitations of Revenue Canada and the rules and regulations of the plan, I herby authorize Wawanesa Life to charge the above claim to my Health Care Spending Account.**

_____ _____

**Signature of Plan Member** **Date**

Drug Dept. P.O. Box 1652, Windsor, ON N9A 7G5
Medical Items, P.O. Box 1623, Windsor, ON N9A 7B3
Vision/Hospital Dept. P.O. Box 1615, Windsor, ON N9A 7J3
Professional Services, P.O. Box 1699, Windsor, ON N9A 7G6
Other Claims, P.O. Box 1606, Windsor, ON N9A 6W1
Dental Dept. P.O. Box 1608, Windsor, ON N9A 7G1

**To avoid additional postage costs, please submit multiple claims in one envelope to any of the addresses listed above. When in doubt, choose the "OTHER CLAIMS" address.**

**For inquiries contact: GROUP CUSTOMER SERVICE Toll Free 1.800.665.7076**

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