HEALTH SPENDING ACCOUNT CLAIM

EMPLOYEE STATEMENT

Employer	Date of Birth	Male o Female o	Group #	Certificate #

Employee Name	Employee Address (Street, Province and Postal Code)

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)

Claimant's First Name	Relationship	Date of Birth Day	Mo.	Yr.	Type of Expense i.e. Drugs, Vision, Practitioner, etc.	Date Expense Was Incurred	Total Amount Charged
(It is recommended that you accumulate at least $100 in total expenses before submitting HSA claims) **TOTAL**							

Falsifying or tampering with claim documents / receipts could have legal consequences

Authorization:

I certify that all information contained in this claim form and all other documents supporting this claim (including all receipts attached) are true, full and complete.

I accept full responsibility that all expenses incurred and submitted for payment from my Health Spending Account are allowable medical expenses as defined under the Income Tax Act (Canada). I declare that the dependents for whom expenses are being submitted are dependent on me for maintenance or support as required by the Canada Revenue Agency.

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 determining my eligibility for the benefits claimed under my plan, and for validating, administering and processing my claim.

I authorize the release and/or exchange of any information relating to this claim to or by RWAM and to or by any other parties, as may be required in order to administer, process and confirm the validity and/or accuracy of this claim. 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 until revoked in writing by myself.

A photocopy or facsimile transmission of this authorization shall be considered as valid as the original.

r _____ _____ ( ) -

SIGNATURE OF EMPLOYEE **DATE** **TELEPHONE NO.**

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