



# EXTENDED HEALTH CARE and HEALTH SPENDING ACCOUNT CLAIM

## EMPLOYEE STATEMENT

Employer	Date of Birth	Male <input type="radio"/> Female <input type="radio"/>	Group & Division #	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			Type of Expense i.e. Drugs, Vision, Practitioner, etc.	Date Expense Was Incurred	Total Amount Charged
		Day	Mo.	Yr.			
(It is recommended that you accumulate at least \$30 in total expenses before submitting a claim)						<b>TOTAL</b>	

Is this claim for a work related accident or sickness on yourself or your dependent(s)? <input type="radio"/> No <input type="radio"/> Yes
If 'Yes', has a claim been submitted to WCB/WSIB? <input type="radio"/> No <input type="radio"/> Yes
If this claim is for a dependent, is the dependent employed? <input type="radio"/> No <input type="radio"/> Yes - If 'Yes' <input type="radio"/> Full-time <input type="radio"/> Part-time
If 'Yes', indicate name and address of dependent's employer:
Does the claimant have any other group health coverage? <input type="radio"/> No <input type="radio"/> Yes
If 'Yes', indicate the name of the employer and the insurance company:

## HEALTH SPENDING ACCOUNT

Do you want the unpaid portion(s) of the above claim(s) to be considered under your Health Spending Account? <input type="radio"/> No <input type="radio"/> Yes - If 'Yes', complete the separate Group, Division & Certificate # assigned to your Health Spending Account <input checked="" type="radio"/>	Group & Division #	Certificate #
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**Falsifying or tampering with claim documents / receipts could have legal consequences**

This form must be completed in full. If not, the form will be returned to you which will delay the processing of the claim.

**Please do not use this form for emergency Out-of-Province/ Out-of-Canada (OOC) claims.**  
All OOC claims must be submitted directly to Mondial Assistance, which administers & services RWAM's Travel Assist plan.  
Mondial's claim form with its address can be downloaded from RWAM's website at [www.rwam.com](http://www.rwam.com).

**Authorization:**

I certify that the expenses listed above and for which the original receipts are attached were incurred by myself or by my eligible dependent(s). The expenses were incurred upon the recommendation and approval of the attending physician (where required by this policy/plan) and were required medical treatment. I declare that the statements made on this form are true, full and complete.

I accept full responsibility that all expenses incurred and submitted for any 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 policy/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.

Mail completed form to: **RWAM INSURANCE ADMINISTRATORS INC.**  
**Attention: Health Claims Department**  
49 Industrial Drive, Elmira, Ontario N3B 3B1