3095 Woodbine Drive, North Vancouver, BC V7R 2S3
Phone 604-980-6227 • Toll-Free 1-800-432-9707 • Fax 604-983-2935
Website: www.jbenefits.com

Attach all invoices, paid receipts and/or any applicable Explanation of Benefits (EOB) as well as any other supporting documentation relevant to your claim. Please retain copies as originals will not be returned.

REQUEST FOR HEALTH SPENDING ACCOUNT (HSA) REIMBURSEMENT

EMPLOYER NAME

Name

EMPLOYEE NAME

Last Name	First Name	Date of Birth

I, the undersigned, hereby request that the expenses outlined below be reimbursed from my HEALTH SPENDING ACCOUNT (HSA), and that to the best of my knowledge, the expenses I am claiming meet with the rules and regulations for Health Care Spending Accounts (HCSA) as set forth by the Canada Revenue Agency.

EMPLOYEE/DEPENDENT NAME

Patient Name	Relationship to Employee	For each Patient Show Only Date of First and Last Receipt	Total Expenses
		From: To:	$
		From: To:	$
		From: To:	$
		From: To:	$
		TOTAL	$ 0.00

Do you have coverage under any other plan? ■ Yes ❑ No If yes, Insurer: _____ Policy #: _____

Who should we pay? ❑ Employee ■ Service Provider

Under Co-ordination of Benefits provisions, if your spouse has coverage under another insurance plan, his/her charges must first be submitted under that plan. Similarly, dependent children claims must first be submitted to the plan of the parent whose month and day of birth comes earlier in the calendar year.

CONTACT INFORMATION (CHEQUE WILL BE SENT TO THIS ADDRESS)

Street Address		
City	Province	Postal Code
Phone Number	Mobile Number	
Email		

Is this a new address? Yes ❑ No ❑ Is this an employer address? Yes ■ No ❑ Is this a service provider address? Yes ❑ No ❑

If there are questions about this claim, how should we contact you? Email ❑ Phone ❑ Mobile Phone ❑ Mail ❑

AUTHORIZATION AND SIGNATURE

I HEREBY CONFIRM:

1. The information contained in this Claim Form is true and complete to the best of my knowledge.
2. The expenses were incurred by myself or one of my dependents and that such expenses are not eligible for reimbursement under the group policy or any other plan and qualify for reimbursement under my Health Spending Account.
3. I am AUTHORIZED to disclose information about dependents with respect to the claim.
4. I understand that any expenses for which I am reimbursed under my Health Spending Account cannot be claimed for income tax purposes. Should any tax consequences arise from the reimbursement of these expenses, I understand I am responsible for payment of such taxes.
5. I certify that the persons for whom I am making a claim are eligible.
6. I AUTHORIZE my Employer and applicable Group Insurer(s) to exchange information detailed in this Claim Form and any other benefit related information related to this claim.

_____	X _____	_____
Employee/Plan Member Name	Employee/Plan Member Signature	Date

THIS FORM MUST BE SIGNED AND DATED

Your Health Spending Account (HSA)

What expenses qualify for reimbursement?

1. Expenses that qualify for the medical expense tax credit under the Income Tax Act are eligible. These may include expenses not covered by your medical or dental coverage (if provided) under your Group Benefits Plan.
2. Expenses which have been paid (or are eligible to be paid) by any government or private insurance plan do not qualify for reimbursement.

Claiming

1. You must submit the expenses during the year in which they occur.
2. The HSA is only to be used for expenses or the portion of the expenses which are not covered elsewhere. For expenses of which a portion is payable under your Group Benefits Plan (your "plan"), you must submit the claim under your plan first. After the benefit has been paid under your plan, you should then submit the unpaid portion of the claim for payment under your HSA.
3. Include your Explanation of Benefits (EOB) form from your primary insurance provider along with your HSA claim and applicable receipts.
4. Include copies of original receipts when you submit with a claim. These receipts must include the following information:
    - Name of the claimant
    - Nature of the treatment or type of medical product
    - Name of the prescribing physician
    - The date the claim was incurred
    - The amount charged
5. Mail or email completed forms to:

    Johnstone's Benefits
    3095 Woodbine Drive
    North Vancouver, BC
    V7R 2S3
    claims@jbenefits.com

6. Please allow 5 business days to process your HSA claim(s). NOTE: processing time may be longer in higher activity months such as December and January.