Health Services Spending Account Form

Member Information (Please Print)

Group #	Certificate #	Member Surname	First Name	Employer, Union, School Name

Member's Home Address	Apt #	Street # and Name	City	Province	Postal Code

Telephone Number: ( )	Work: ( )	Email

COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENTS

Dependent's Name (Last, First)	Date of Birth (day/month/year)			Relationship to Plan Member
				Spouse Daughter Son Other (describe)
				Spouse Daughter Son Other (describe)

I certify that I have read and understood the Grandeur Privacy Policy posted on Grandeur Group Benefits Inc.'s (**"Grandeur"**) website at http://grandeurbenefits.com/ (the **"Policy"**) and I consent to the collection, use and disclosure of my personal information for the purposes of group benefits plan administration, including, adjudicating, assessing and processing my claim, audit, investigation, underwriting or determining plan eligibility, and for communicating with me about my claim (**"Purposes"**). I certify that the above information is true and complete and that the claimed costs and/or charges were paid for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized by my dependents to disclose and receive information about my dependents for the Purposes. I acknowledge that unless assigned to the service provider, any reimbursement of the claimed charges and explanation of such amounts paid will be provided to the benefit plan member identified in this claim form. I authorize Grandeur, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with Grandeur to release and exchange necessary personal information regarding this claim for the Purposes. I authorize Grandeur, and persons acting for it, to disclose any relevant personal information contained in this claim, to the benefit plan sponsor/employer for the Purposes. I acknowledge and agree that under certain circumstances Grandeur, or persons acting on its behalf, may be required by applicable law to disclose personal information contained in this claim to others without my knowledge or consent, or the consent of the individual to whom the personal information in this claim relates. In all other circumstances, Grandeur will only disclose my personal information, or the personal information of my dependents, in accordance with the Privacy Policy posted on Grandeur's website at http://grandeurbenefits.com/. We may revise the Privacy Policy from time to time, and will post the most current version on our website at http://grandeurbenefits.com/. Please check back from time to time to ensure that you are aware of any changes and are using the most recent version of the Privacy Policy. We will indicate at the top of the page the date the Privacy Policy was last revised. Your continued use of the attached claims form and the related website after any such changes constitutes your acceptance of the P

Health Services Spending Account Signature

I wish any portion of my claim not paid by my Extended Health or Dental plan to be reimbursed from my Health Services Spending Account.

I hereby certify that the above expenses are considered eligible by Revenue Canada to be payable from a Health Services Spending Account.

Signature: ____ Date: ____

EXPENSES (Attach original receipts and list below)

Nature of expense	Date incurred (dd/mm/yyyy)	Amount

1. Are any health benefits or services provided under any other group insurance or health plan, Worker's Compensation or government plan? Yes No

2 b. Name of other insuring agency or plan: ____

Total Claim $

2 a. If yes, indicate member under other plan: Self Spouse

Policy No. ____________________________ Certificate No. ____________________________

Name: ____________________________ Date of Birth [Day | Month | Year]

N.B. For coordination of benefits, children must claim under the plan of the parent with the earlier month and day of birth in the calendar year

*** Note: Do NOT staple or tape receipts to the claim form ***

All information recorded on this form is confidential

Send all claims and inquiries to:

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