Manulife Financial

Group Benefits
Health Care Spending Account (HCSA) Claim

This form is to be completed by the plan member. Receipts must be attached for all expenses. (Please attach to the back of this form.) Please retain copies for your files as receipts will not be returned.

1 Plan member information

Plan contract number	Division number	Plan member certificate number	Plan sponsor

Plan member name (first, middle initial, last)	Birthdate (dd/mmm/yyyy)

Plan member address (number, street and apt.)	City or town	Province	Postal code

2 Patient information

Complete for all expenses. Use one line per patient.

Patient's name	Date of birth (dd/mmm/yyyy)	Relationship to plan member

3 Type of HCSA claim submission

Please check ✓ one of the following:

No spouse or dependant coverage

◯ You are claiming for a health or dental expense that is covered by your health or dental plan, but not covered by any spousal or dependant plan. If you want any outstanding amount under your health or dental plan submitted to your HCSA, please ensure you enclose:
- **original** receipts,
- your completed Extended Health Care or Dental claim form, and
- your completed HCSA claim form.

Spouse or dependant coverage - Manulife Financial first payor

◯ You are claiming for a health or dental expense for which you received partial reimbursement from your health or dental plan and your spousal or dependant plan. If you want the outstanding amount to be submitted to your HCSA, please ensure you enclose:
- **copies** of receipts,
- all insurance carrier's claim statement(s)/explanation of benefit form(s), and
- your completed HCSA claim form.

Spouse or dependant coverage - Manulife Financial second payor

◯ You are claiming for a health or dental expense for which you received partial reimbursement from your spousal or dependant plan. If you want the outstanding amount to be submitted to your health or dental plan and then your HCSA, please ensure you enclose:
- **copies** of receipts,
- the other insurance carrier's claim statement(s)/explanation of benefit form(s),
- your completed Extended Health Care or Dental claim form, and
- your completed HCSA claim form.

No coverage

◯ You are claiming for a health or dental expense that is not covered under any plan. If you want the expense submitted to your HCSA, please ensure you enclose:
- **original** receipts, and
- your completed HCSA claim form.

4 Mailing instructions

- Staple your receipts and, if applicable, your health or dental claim form(s) and insurance carrier's claim statement(s)/explanation of benefit form(s) to the back of the claim form.
- Place your completed claim form in an envelope and mail to this address.

MANULIFE FINANCIAL
GROUP HEALTH CLAIMS
PO BOX 2580 STN B
MONTREAL QC H3B 5C6

Please complete next page.

5 Claims confirmation

Total amount of **ALL** receipts submitted: **$**

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I understand** that expenses reimbursed under the Health Care Spending Account may not be claimed for personal income tax. **I understand** that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Please sign here

Plan member's signature	Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.