



Health Spending Account Claims Authorization

to reduce the Administration expenses, please submit Claims Forms when the Total Claims are at least \$100

Name of the Employer

Employee's Last Name	First Name	Initials	Single or Family	Benefit Class
_____	_____	_____	_____	_____

Employee Reimbursement

use one Summary of Claims line (below) for all Claims if for the same Claimant and enter relation to Employee

Last Name of Claimant	First Name	Relationship to Employee	Amount of Claim
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Sub-total: Reimbursement to Employee

Service Provider Payment

use one Summary of Claims line (below) for all Claims if for the same Claimant and the same Service Provider

Last Name of Claimant	First Name	Name of Service Provider	Amount of Claim
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Sub-total: Payment to Service Providers

Calculation and Payment

Total Claims:

signature of eligible Employee

date of signature

Instructions

Retain Copies of Claims, Receipts and Statements
Send Originals for Payment to Assureflex Corporation
Post Office Box 81, Strathroy, Ontario N7G 3J1