

FOR OFFICE USE ONLY
REGISTRATION No. _____

## CLAIM FOR HEALTH CARE SPENDING ACCOUNT BENEFITS

\_\_\_\_\_  
POLICY NO. I.D. / CERTIFICATE NUMBER

COMPLETE THIS FORM,  
ATTACH ORIGINAL RECEIPTS  
AND FORWARD TO:

\_\_\_\_\_  
EMPLOYEE NAME

**D.A. TOWNLEY & ASSOCIATES LTD.**  
101 – 4190 LOUGHEED HIGHWAY  
BURNABY, BC V5C 6A8

\_\_\_\_\_  
EMPLOYEE ADDRESS CITY POSTAL CODE

\_\_\_\_\_  
EMPLOYER NAME

**LIST EXPENSES BELOW, GROUPED BY INSURED PERSON, IN DATE ORDER**  
YOUR ORIGINAL RECEIPTS MUST BE ATTACHED TO THIS CLAIM FORM. IF YOU OR YOUR DEPENDENTS ARE COVERED UNDER ANY OTHER INSURANCE OR SUPPLEMENTARY HEALTH PLAN, YOU MUST APPLY FOR REIMBURSEMENT FROM THOSE PLANS FIRST. THE HEALTH CARE SPENDING ACCOUNT IS THE LAST AND FINAL PAYER OF EXPENSES. IN CASE OF DUAL COVERAGE, SEND STATEMENT OF PAYMENT FROM PRIMARY AND SECONDARY INSURERS ALONG WITH PHOTOCOPIES OF ORIGINAL RECEIPTS.

NAME (EMPLOYEE OR INSURED DEPENDENT)	RELATIONSHIP TO EMPLOYEE	BIRTH DATE (YR/MO/DAY)	DATE OF PURCHASE	CLAIM DESCRIPTION	AMOUNT CHARGED

ARE YOU AND/OR YOUR DEPENDENTS COVERED UNDER ANY OTHER INSURANCE OR SUPPLEMENTARY HEALTH PLAN? YES _____ NO _____ If YES, UNDER POLICY _____ NAME OF INSURING AGENCY: _____ NAME OF INSURED: _____ ID/CERTIFICATE: _____ DATE OF BIRTH: _____
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I UNDERSTAND THAT D.A. TOWNLEY & ASSOCIATES LTD. COLLECTS PERSONAL INFORMATION TO ASSESS ELIGIBILITY FOR BENEFITS; TO DETERMINE AND ADJUDICATE BENEFITS, TO DETERMINE THE COST AND FINANCIALLY MANAGE THESE BENEFITS, AS WELL AS TO MEET REGULATORY OR CONTRACTUAL REQUIREMENTS RELATING TO SUCH BENEFITS AND RELATED SERVICES PROVIDED. I AUTHORIZE THE RELEASE OF THE INFORMATION PROVIDED ON OR ATTACHED TO THIS FORM TO BE USED FOR CLAIMS ADJUDICATION PURPOSES AND STATISTICAL ANALYSIS. TO THE BEST OF MY KNOWLEDGE, THE ABOVE HEALTH-RELATED EXPENSES I AM CLAIMING MEET WITH THE RULES AND REGULATIONS FOR HEALTH CARE SPENDING ACCOUNTS AS SET FORTH BY CANADA REVENUE AGENCY.

\_\_\_\_\_  
EMPLOYEE'S SIGNATURE

\_\_\_\_\_  
DATE

CLAIMS REF#
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