CLAIM FORM - MEDICAL EXPENSES & HSA

myGroupHEALTH

Group#	Certificate/ID#
Company Name	
Member Surname	First Name
Date of Birth(day/month/year)	Preferred Language ☐ English ☐ French

Member's Address Apt #	Street# and Name	
City	Province	Postal Code
Phone# Home	Work	
Cell Phone	Email	

Are your group health benefits payable from any other source? ☐ Yes ☐ No

Insurance Company Name	Policy Number	Certificate Number

Are the expenses the result of an accident? ☐ Yes ☐ No If yes, where did the accident occur? ☐ Work ☐ Home ☐ Other

Are any expenses the result of a condition covered by Worker's Compensation? ☐ Yes ☐ No

MEDICAL EXPENSES (Attach original receipts for expenses listed below; do NOT staple or tape receipts to the claim form) Please print

*Health Spending Account (HSA)
Do you wish to have any unpaid balance from your claims paid by your HSA? ☐ Yes ☐ No
If yes, check 'HSA' next to any expenses where this applies.

Name (member or insured dependent)	Relationship to Member	Date of Birth			Total	HSA
		day	month	year		
1)					$	☐
2)					$	☐
3)					$	☐
4)					$	☐
5)					$	☐
6)					$	☐
7)					$	☐
8)					$	☐
9)					$	☐
				Total	$	

Please check the box if any of the above expenses are for Hospital Indemnity. ☐

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purpose of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement for the above charges and explanation of such amounts paid will be provided to the benefit plan member.

I authorize GroupHEALTH, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with GroupHEALTH to exchange necessary information regarding this claim to administer my health benefit plan.

Date: _____ Member's Signature: _____

Please send claim form to: myGroupHEALTH 626-21 Four Seasons Place, Toronto ON M9B 0A5 | 1-833-344-6944

*For quick and easy claim submission, submit claims at **mygrouphealth.ca** or with the **myGroupHEALTH app** available in the Apple App Store or Google Play.*