CoRe GROUP BENEFITS

★ ★ CLAIM FORM - HEALTH SPENDING ACCOUNT ★ ★

(HSA2018)

PART 1 EMPLOYEE INFORMATION

EMPLOYER: _____

Employee Number: Employee Name: Employee email address: _____

_____ _____

last name first name middle initial

PART 2 CLAIM DETAILS

Is treatment required as the result of an accident? If yes, attach accident details. Provide date, location and explain how accident happened.	☐ Yes	☐ No
Is a claim being made for Worker's Compensation Benefits?	☐ Yes	☐ No
Is this an ICBC case?	☐ Yes	☐ No

At CoRe Group Benefits we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize CoRe Group Benefits, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits program, other organizations, or service providers working with the employer to exchange personal information when necessary for these purposes.

I certify that the information given is true, correct and complete to the best of my knowledge.

EMPLOYEE SIGNATURE _____ **Date** _____

An administration fee will be charged if your banking information has changed without notice to CoRe Benefits.

Order of Benefit Payment: If you or your spouse is covered for similar benefits under another Plan, this information will be taken into account when determining the amount of expenses payable under this Program. This process is known as **Co-ordination of Benefits**. It allows for reimbursement of covered extended healthcare expenses from all Plans, up to a total of 100% of the actual expense incurred.

A variety of circumstances will affect which Plan is considered as the "*Primary Carrier*" (i.e., responsible for making the *initial payment* toward the eligible expense), and which Plan is considered as the "*Secondary Carrier*" (i.e., responsible for making the payment to cover the remaining eligible expense.

For Claims incurred by you or your dependent spouse:

The Plan covering you or your dependent spouse as an **employee/member** is considered the ***Primary Carrier*** and pays benefits first. The Plan covering you or your spouse as a **dependent** is considered the ***Secondary Carrier*** and pays the balance of the eligible expense.

For Claims incurred by your dependent child:

The Plan covering the parent whose birthday ***(month/day)*** is *earlier* in the calendar year pays benefits first.

INSTRUCTIONS:

1. Please answer all of the questions and **sign** and **date** this claim form. This claim will be returned to you if it is incomplete or contains errors.
2. Enclose all original receipts when submitting to CoRe Group Benefits as the primary carrier. *If you also have coverage with another benefit carrier**, make a photocopy of all receipts** before sending the originals to CoRe Group Benefits*.
3. **IF** you are claiming for the balance not paid by another benefit carrier, include **photocopies of your receipts** and their **payment statement**.
4. Receipts, other than those required for government drug plans, are part of our records and will **not** be returned. Therefore, please retain the itemization of expenses that will accompany our reimbursement ($) or explanation for income tax purposes.
5. **SHOULD YOUR MARITAL STATUS, DEPENDENT INFORMATION OR SPOUSAL GROUP HEALTHCARE COVERAGE CHANGE, NOTIFY US IMMEDIATELY!**

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EXPENSE INFORMATION

Please list your extended health care expenses in **date** order.

Date of Service (mm/dd/yyyy)	Name of Dependent	Type of Service*	Cost of Service	Amount paid by co-insurer (if applicable)
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
11.			$	$
12.			$	$
13.			$	$
14.			$	$
15.			$	$
16.			$	$

TOTALS: $_____ $ _____

HSA CLAIM EXPENSES ARE REIMBURSED IN THEIR ENTIRETY, DEPENDING ON THE AVAILABLE CREDITS. REQUESTS FOR PARTIAL REIMBURSMENTS CANNOT BE ACCOMMODATED.

Please note that **Type of Service** refers to ***what kind of claim you are submitting; for example, dental, paramedical services (physiotherapy, chiropractor, massage therapy, etc.) vision care or medical service and/or supply expenses.

MAIL THIS CLAIM TO:
CoRe Group Benefits
#110 – 1121 MacFarlane Way
Merritt, B.C.
V1K 1B9
For questions or inquiries: 250-378-9872 Email: admin@coregroupbenefits.org