NO STAPLES PLEASE, PAPER CLIPS ONLY

Clear

HEALTH CARE SPENDING ACCOUNT (HCSA) CLAIM SUBMISSION FORM

each person must complete their own claim form

Did you know that most claims can be submitted online, and you could receive your claim payment faster with direct deposit? Go to www.wawanesalife.com for more details

This form should be used when claiming reimbursement under your Health Care Spending Account, Health Care Expense Account or Health Services Spending Account for eligible expenses which are not covered (or not covered in full) by your Health or Dental Plan.

PLAN MEMBER INFORMATION

PLAN MEMBER ID	EMAIL ADDRESS
SURNAME FIRST NAME	
ADDRESS	PHONE NUMBER
CITY	PROVINCE POSTAL CODE

MANDATORY DECLARATION

Do you have any other group insurance coverage that may include these services as benefits? YES ☐ NO ☐

If other coverage is with Wawanesa Life, indicate Plan Member ID: _____

Be sure you have first submitted these claims to any provincial health insurance, or any private health care plan you may have (including another Wawanesa Life plan, spousal plan, etc.).

If we are your secondary carrier, please attach copies of your receipt and your Explanation of Benefit statement from your primary carrier.

☐ I want my eligible expenses paid from my Wawanesa Life health plan or dental plan **first** and any unpaid portions of my eligible expenses paid from my HCSA.

☐ I want all my eligible expenses paid from my Wawanesa Life health plan or dental plan **first**, then any unpaid portions of my eligible expenses paid from my other Wawanesa Life #_____and if still unpaid portion remaining, paid under my HCSA.

☐ I want all my eligible expenses paid directly from my HCSA.

NOTE: *If no box has been checked, we will pay claims according to the first option above.*

PATIENT'S NAME	DEPENDENT NO. (e.g. WLI1234567-01)	DATE OF BIRTH YY	MM	DD

HEALTH CARE EXPENSES (Please include receipts, prescriptions, etc.)

DESCRIPTION OF EXPENSE	DATE OF EXPENSE	AMOUNT
	TOTAL AMOUNT CLAIMED	$

AUTHORIZATION AND CONSENT

At Wawanesa Life ("**we**," "**us**" or "**our**"), respecting and protecting the privacy and confidentiality of your personal information is a priority. In order to provide you with the services for which we have been engaged, we need you to understand, and consent to, a few things. We may collect/receive from you or other parties and use, share, disclose and process your personal information and, if applicable, that of your spouse, children and other dependents (collectively, "**you**" or "**your**"), which may include name, age, claims history, income, email address, service providers that may have been used and banking information. We may do this for various purposes related to the administration of your benefits plan and to provide you other products and services, including but not limited to: benefits coordination with other carriers; administration and adjudication of claims; auditing, investigating, and taking steps connected to the prevention or suppression of suspected or proven improper or fraudulent claims; identity checks; billing and collection of premiums; medical underwriting; communication with other service providers, communication with third parties to confirm the accuracy of claims, provide contracted services, or for health management purposes or programs; collecting information about services that are provided, analyzing data, including information on how you use our products and services, to help us make informed decisions and improve the products and services we offer; determining if there are other products and services that you might be interested in, and sending you details about them; compliance with applicable laws and regulations; and such other activities that a reasonable person would consider associated with the administration of your benefit plan. In carrying-out these purposes, we may collect, receive, share or disclose your personal information with others outside of Wawanesa Life, including, but not limited to: your employer, sponsor(s) of your benefit plan, and insurance advisors, if your benefits are provided through your employer's group benefits plan; benefits providers (e.g. pharmacists, massage therapists); professional regulatory bodies (e.g. College of Pharmacists); government agencies; applicable law enforcement bodies (local, provincial and federal); industry drug pooling entities (e.g. Canadian Drug Insurance Pooling Corporation); Wawanesa Life's third party service providers who assist us in administering your benefits plan and providing you with other related products and services and such other third parties as may be appropriate or reasonably necessary in carrying out the purposes set out above. Although sharing of personal information is inherently risky, we implement commercially-acceptable procedures to secure and protect your personal information using appropriate technological, physical and organizational measures designed to protect personal information. In the event of an unauthorized release by us of your personal information, we will notify you in accordance with applicable privacy laws. More information about our privacy practices is available in our Privacy Policy at www.wawanesalife.com, which is a necessary and integral part of this privacy consent. We may from time to time revise our Privacy Policy to reflect changes in, for example, legislation or regulation, or as we introduce new features, products or services. The most current version of the policy will govern how we process your personal data and will always be available on www.wawanesalife.com. You can contact our Privacy Officer at privacy@wawanesa.com if you have a question or complaint.

By signing below, you are providing your consent to Wawanesa Life's collection, use and disclosure of your personal information as explained above, and you are acknowledging that you are authorized by your spouse, children and other dependents (if applicable) to disclose and receive their personal information, and to provide this privacy consent on their behalf. You agree that a photocopy, facsimile or electronic version of this consent will be as valid as the original. You can withdraw your consent at any time by providing notice in writing to Wawanesa Life at privacy@wawanesa.com, but, if you do so, Wawanesa Life will no longer be able to administer your benefits plan and process your claims.

Subject to the limitations of Canada Revenue Agency and the rules and regulations of the plan, I hereby authorize Wawanesa Life to charge the above claim to my Health Care Spending Account.

Name	**Signature**	**Date**

MAILING INSTRUCTIONS

Mail this form and enclosures to:

WAWANESA LIFE
Attention: Health Care Spending Account

PLEASE ATTACH ALL ORIGINAL DOCUMENTATION and retain copies for your files as original receipts will not be returned.

Send your claim to the corresponding address below (be sure to indicate the full address on the envelope):

PROFESSIONAL SERVICES	MEDICAL ITEMS	VISION & ACCOMMODATION	DRUG	DENTAL
P.O. BOX 1699 WINDSOR, ON N9A 7G6	P.O. BOX 1623 WINDSOR, ON N9A 7B3	P.O. BOX 1615 WINDSOR, ON N9A 7J3	P.O. BOX 1652 WINDSOR, ON N9A 7G5	P.O. BOX 1608 WINDSOR, ON N9A 7G1

To avoid additional postage costs, please submit multiple claims in one envelope to any of the addresses listed above.

Please call our Group Customer Service at 1.800.665.7076 if you require any assistance in completing this form.

The cost, if any, of obtaining this information is at the expense of the Patient/Plan Member.