HealthSource Plus®

Claims for Group Health Benefits (with Health Spending Account) Claim Form

HSP 3B 04.2010

A. Employee/Employer Information

Employer's Name:	Group #:	Certificate #:

				Birth Date		
Employee's Last Name:		Language	Sex	D	M	Y
Employee's First Name:		☐ English ☐ French	☐ M ☐ F			

Mailing Address

Street, Suite No. City Province Postal Code

DO YOU WANT ANY UNPAID BALANCE FROM THIS CLAIM REIMBURSED FROM YOUR HEALTH CARE SPENDING ACCOUNT (IF ELIGIBLE)? ☐ YES ☐ NO

B. Claim Information

IMPORTANT: Please complete all requested information and list expenses in date order. Use a separate line for each person and **attach original receipts**.
Unsigned and incomplete forms or photocopied receipts cannot be processed for payment.

Patient's Name	Relationship to Employee	Birth Date			Is Dependent child full time student?	Receipt date			Nature of Expense	Total Charge
		D	M	Y		D	M	Y		
					☐ Yes* ☐ No					
					☐ Yes* ☐ No					
					☐ Yes* ☐ No					

If child is 21 or over and registered as a full time student, please indicate the school name and the most recent date of registration**. ***In Quebec – age according to plan design.

Dependent Last Name, First Name	Name of School	D	M	Y

C. Coordination of Benefits (For coordination of benefits, children must claim under the plan of the parent with the earlier month and day of birth in the calendar year)

1. Are any of these expenses related to a Workers' Compensation Claim? ☐ Yes ☐ No

2. Are benefits available from another group plan? ☐ Yes ☐ No
   If yes, please provide the Insurance Carrier Name: Policy #:

D. Employee Authorization

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 purposes of assessing and paying a benefit, if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member.
I understand that Health Source Plus Inc. shall have the right to recover from myself and/or my dependents any payments made in error or as a result of fraud, as well as any costs related directly to the recovery of such funds
I authorize ClaimSecure, Health Source Plus, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure and Health Source Plus to exchange necessary information regarding this claim to administer my health benefit plan.

Name (Please Print) Signature Date Signed (dd/mm/yyyy)

Submit Form To: ClaimSecure Inc., P.O. Box 6500, Station A, Sudbury, ON P3A 5N5 (1-888-513-4464)