HEALTH CARE SPENDING ACCOUNT
CLAIM SUBMISSION FORM

Green Shield I.D. #	**Alternate I.D. #**	**Date of Birth** _____/_____/_____ YY MM DD
Surname	**First Name**	
Mailing Address		**Telephone #** ( )
City	**Province** / **Postal Code**	

Be sure you have first submitted these claims to any provincial health insurance or any private health care plan you may have.

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

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

Description of Expense	Date of Expense	Name	Dependent #	Amount
			Total Amount Claimed	**$**

By signing this claim form and/or submitting original receipts, I agree that the information provided is complete and accurate, to the best of my knowledge. I authorize Green Shield Canada to exchange information with other parties as required and only when the information is needed to administer this benefit claim and/or to confirm the accuracy of this information.

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

_____
Signature of Subscriber

Mail this form and enclosures to: GREEN SHIELD CANADA
Attention: Health Care Spending Account

PLEASE INDICATE ON MAILING ENVELOPE

Drug Dept. P.O. Box 1652, Windsor, ON N9A 7G5
Medical Items, P.O. Box 1623, Windsor, ON N9A 7B3
Vision/Hospital Dept. P.O. Box 1615, Windsor, ON N9A 7J3
Prof. Services, P.O. Box 1699, Windsor, ON N9A 7G6
Out-of-Country, P.O. Box 1606, Windsor, ON N9A 6W1
Dental Dept. P.O. Box 1608, Windsor, ON N9A 7G1

For inquiries contact: CUSTOMER SERVICE CENTRE
Toll Free 1-888-711-1119 or 519-739-1133

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