Health Spending Account Claim Form

Regency
ADVISORY CORPORATION
200 - 261, First Avenue North
Saskatoon | SK | S7K 1X2
PH: (306) 665 - 3377

Submit Claims - EMAIL: claims@regencyadvisors.com | FAX: (306) 665 - 3379

CLIENT INFORMATION:

Policy Number	Group Name	Date of Birth	Month	Day	Year

Member's Surname	First Name

Has your address changed in the past year? ☐ Yes ☐ No Date Moved:	Street Address/Box Number		
	City, Province	Postal Code	
	Home / Cell Phone Number	Work Phone Number	

PLEASE NOTE:

Please record the total number of Receipts submitted: ☐

I understand that all receipts submitted here are not eligible for reimbursement under my group insurance plan (if applicable). I have attached proof of payment - or lack thereof - by the other company (if applicable). ☐ *Initials*

SPOUSE/DEPENDENT INFORMATION:

Relationship to Member		First Name	Last Name *(if Different from Member)*	Date of Birth Month	Day	Year	Provincial Health Number	Dependent Information *(For any over age dependents, please indicate name of full-time educational facility being attended)*
1	SPOUSE							
2	CHILD							
3	CHILD							
4	CHILD							
5	CHILD							

OTHER COVERAGE:

Are you or your dependents entitled to receive comparable benefits from any other insurance company or health benefits company?

☐ Yes ☐ No If yes, please complete the following: ☐ Health ☐ Dental ☐ Drugs

Name of insurance company or other Health Benefits Company:

Name of Insured/Policyholder:

Date of Birth: (Month/Day/Year)

Policy Identification Number/Section Number:

Effective Date:

Cancel Date:

AUTHORIZATION AND CONSENT:

I certify all information submitted is true and complete and I have not claimed and will not claim these expenses under any other insurance plan (unless indicated above). I acknowledge my understanding of the purpose for which personal information is collected, used, and discolsed and consent to use of this information for myself and/or any covered dependent in accordance with the privacy protection practices of this insurance policy and any other parties as required in order to administer and/or confirm the accuracy of this claim. I understand that I may revoke my consent at any time. A photocopy of this authorization and consent shall be as valid as the original. This consent complies with federal and provincial privacy laws.

NAME OF CLAIMANT *(Please print)* | SIGNATURE OF CLAIMANT/MEMBER | DATE