CLAIM FORM FOR PERSONAL SPENDING ACCOUNT (PSA)

This form should be used when claiming reimbursement under your personal account (PA). This is not a Health Care Spending Account (HCSA) claim form. Please use one form per person.

SECTION 1 – PATIENT INFORMATION

GREEN SHIELD CANADA ID NUMBER	SOCIAL INSURANCE NUMBER

SURNAME	FIRST NAME	DATE OF BIRTH (YY/MM/DD)

ADDRESS	TELEPHONE NUMBER

CITY	PROVINCE	POSTAL CODE

Please note expenses will be limited to the benefits specifically outlined under your contract. Please refer to your benefit booklet for coverage details. Benefits provided by your PSA are taxable. Claim will be taxed based on the year the claim was *processed* and not the year the claim was incurred.

SECTION 2 – CLAIM DETAILS

DESCRIPTION OF EXPENSE	DATE OF EXPENSE YR	MO	DAY	NAME	RELATIONSHIP TO EMPLOYEE	CHARGES $
					TOTAL	

SECTION 3 – AUTHORIZATION

SUBJECT TO THE LIMITATIONS AND THE RULES AND REGULATIONS OF THE PLAN, I HEREBY AUTHORIZE GREEN SHIELD CANADA TO CHARGE THE ABOVE CLAIM TO MY PERSONALSPENDING ACCOUNT.

PLAN MEMBER SIGNATURE _____ DATE _____

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependents, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.

I further authorize Green Shield Canada to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.

SECTION 4 – MAILING INSTRUCTIONS

PLEASE ATTACH ALL ORIGINAL CORRESPONDENCE and retain copies for your files as original receipts will not be returned.
THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.

PLEASE INDICATE ON MAILING ENVELOPE:

GREEN SHIELD CANADA
P.O. BOX 1699, WINDSOR, ON N9A 7G6
ATTENTION: PERSONAL SPENDING ACCOUNT

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133
greenshield.ca