CINUP

HEALTH SPENDING ACCOUNT REQUEST

JG13-CU

This form is to be used to claim eligible expenses up to the maximum allowed under the Health Spending Account (HSA) portion of your plan. The form must be completed in full or it will be returned without reimbursement.

1

If you would like to coordinate expenses between your group insurance plan and your Health Spending Account, please attach this request to a completed Extended Health Care or Dental claim form with the receipts.

or

If you have already submitted a claim and you would like the unpaid portion to be reimbursed, please remit this form along with the original Explanation of Benefits (EOB).

EMPLOYEE INFORMATION

Firm Name _____ Firm # _____

Employee's Full Name _____ Certificate # _____

Amount Submitted $_____

2

DECLARATION

All the information I have provided on the form is accurate and complete, to the best of my knowledge, and represents a claim for services rendered to me and/or eligible members of my family. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them for the purposes of assessing and paying a benefit, if any.

I certify that the amount qualifies as a medical expense for income tax purposes. I also acknowledge that the persons for whom I am making a claim are eligible and include myself, my spouse and any dependents as defined under the Health Spending Account coverage. I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes.

I authorize CINUP to collect, use, maintain and disclose personal information relevant to this claim for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. A photocopy of this authorization is as valid as the original.

Signature of Employee _____ Date _____

3

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL

Submit this form, along with a completed claim form or Explanation of Benefits, to

CINUP, 1051 King Edward Street, Winnipeg, MB R3H 0R4
1-800-665-1234 | Fax 1-800-457-8410