



Health Spending Account Claims Authorization

claims are subject to a \$3.75 processing fee
claims under \$100 also subject to \$5.00 processing fee

Company Name of Employer

Employee's Last Name	First Name	Initials	Single Family	Benefit Class

Employee Reimbursement for payment to the Employee

use only one line (below) to total all expense receipts
if for the same claimant, and enter relation to employee

Amount of Claim
including any tax

Last Name of Claimant	First Name	Relationship to Employee	Amount of Claim

Sub-total: Reimbursement to Employee

Service Provider Payment for payment to the Providers

use only one line (below) to total all expense receipts
if for the same claimant and the same service provider

Amount of Claim
including any tax

Last Name of Claimant	First Name	Name of Service Provider	Amount of Claim

Sub-total: Payment to Service Providers

Totals: Employee and Service Providers

Employee Authorization must be dated by Employee

date of signature

Employee Authorization must be signed by Employee

signature of eligible employee

Instructions for Submitting Claims

Send Authorization, Receipts and Statements, by either:

Toll Free Fax: 1 (855) 280-3295

Email: mailroom@assureflex.com as PDF attachment

Mailing Address: 41 - 76 Cortland Terrace, St. Thomas, Ontario N5R 0L2

Retain Copies of Authorization, Receipts and Statements