D.A. Townley

4250 CANADA WAY, BURNABY BC V5G 4W6
TEL: (604) 299-7482 FAX: (604) 299-8136
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CLAIM FOR HEALTH CARE SPENDING ACCOUNT BENEFITS

POLICY NO. I.D. / CERTIFICATE NUMBER

EMPLOYEE NAME

EMPLOYEE ADDRESS CITY POSTAL CODE

EMPLOYER NAME

Complete this form, attach all applicable receipts and forward to:
D.A. TOWNLEY
4250 Canada Way
Burnaby, BC V5G 4W6
or submit by Fax: (604) 299-8136
or Email: health@datownley.com

LIST EXPENSES BELOW, GROUPED BY INSURED PERSON, IN DATE ORDER

PLEASE INCLUDE ALL APPLICABLE RECEIPTS. IF YOU OR YOUR DEPENDENTS ARE COVERED UNDER ANY OTHER INSURANCE OR SUPPLEMENTARY HEALTH PLAN, YOU MUST APPLY FOR REIMBURSEMENT FROM THOSE PLANS FIRST. THE HEALTH CARE SPENDING ACCOUNT IS THE LAST AND FINAL PAYER OF EXPENSES. IN CASE OF DUAL COVERAGE, SEND STATEMENT OF PAYMENT FROM PRIMARY AND SECONDARY INSURERS ALONG WITH PHOTOCOPIES OF ORIGINAL RECEIPTS.

NAME (EMPLOYEE OR INSURED DEPENDENT)	RELATIONSHIP TO EMPLOYEE	BIRTH DATE (YR/MO/DAY)	DATE OF PURCHASE	CLAIM DESCRIPTION	AMOUNT CHARGED

ARE YOU AND/OR YOUR DEPENDENTS COVERED UNDER ANY OTHER INSURANCE OR SUPPLEMENTARY HEALTH PLAN? YES_____ NO _____
IF YES, UNDER POLICY _____ NAME OF INSURING AGENCY: _____
NAME OF INSURED: _____ ID/CERTIFICATE:_____ DATE OF BIRTH: _____

I UNDERSTAND THAT D.A. TOWNLEY COLLECTS PERSONAL INFORMATION TO ASSESS ELIGIBILITY FOR BENEFITS; TO DETERMINE AND ADJUDICATE BENEFITS, TO DETERMINE THE COST AND FINANCIALLY MANAGE THESE BENEFITS, AS WELL AS TO MEET REGULATORY OR CONTRACTUAL REQUIREMENTS RELATING TO SUCH BENEFITS AND RELATED SERVICES PROVIDED. I AUTHORIZE THE RELEASE OF THE INFORMATION PROVIDED ON OR ATTACHED TO THIS FORM TO BE USED FOR CLAIMS ADJUDICATION PURPOSES AND STATISTICAL ANALYSIS. TO THE BEST OF MY KNOWLEDGE, THE ABOVE HEALTH-RELATED EXPENSES I AM CLAIMING MEET WITH THE RULES AND REGULATIONS FOR HEALTH CARE SPENDING ACCOUNTS AS SET FORTH BY CANADA REVENUE AGENCY.

EMPLOYEE'S SIGNATURE DATE

CLAIMS REF#