**BRICKLAYERS & ALLIED CRAFTWORKERS INSURANCE**
**BENEFIT TRUST FUND OF ALBERTA AND SASKATCHEWAN**

# HEALTH SPENDING ACCOUNT CLAIM FORM

***Use this form*** to submit claims to be paid from your Health Spending Account. Refer to your Pan Booklet for a list of expenses which qualify. ***Do not use this form for claims covered under your group benefits plan.***

## MEMBER INFORMATION

| | | | |
|---|---|---|---|
| **LOCAL UNION** | | | |
| **LAST NAME** | **FIRST NAME** | | **CERTIFICATE NUMBER** |
| **ADDRESS** | | **DATE OF BIRTH** (MM/DD/YY) | **GENDER** Male Female |
| **CITY** | **PROVINCE** | **POSTAL CODE** | **PHONE NUMBER** |

## If claim is on behalf of an eligible dependent, please answerer the following

| | | | |
|---|---|---|---|
| **DEPENDENT NAME** | **STATUS** ☐ Spouse ☐ Child | **GENDER** ☐ Male ☐ Female | **DATE OF BIRTH** MM/DD/YY) |
| If the claim is for a dependent child 18 years of age or older, please indicate:<br>School Name _____ | **STUDENT STATUS** ☐ Full-time ☐ Part-time | | **EXPECTED DATE OF GRADUATION** (MM/DD/YY) |

## List and attach all paid receipts or invoices for this claimant

| ITEM SUBMITTED | NAME OF SUPPLIER | DATE OF PAID RECEIPT | AMOUNT CHARGED |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Funds Administrative Service Inc. to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize the release of the information contained in this claim form to the Insurer/Plan Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the claim and to administer the group benefit plan, I certify that the information given is true, correct and complete to the best of my knowledge and that each of the above expenses are for medical treatment that I and/or my dependents received. I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the supplier for the entire amount.

**SIGNATURE OF MEMBER** **DATE** (MM/DD/YY)


**Please return to:**
Funds Administrative Service Inc.
10154 – 108 Street NW, Street Edmonton AB, T5J 1L3
Phone (780) 452-5161 Toll free: 1-800-770-2998 Fax (780) 452-5388