ALBERTA BLUE CROSS®

ab.bluecross.ca

HEALTH/DENTAL PLAN RATE REIMBURSEMENT FORM

The portion of rates paid by employees and/or their dependents for a private health or dental plan are eligible for reimbursement through a Health Spending Account (HSA). Rates for employer-paid benefit portions are not eligible.

Please ensure your employer has authorized the form, as without this signature we are unable to reimburse you.

Please note: If you are requesting reimbursement of health/dental rates paid through your spouse's benefit plan, please have the authorized officer or plan administrator for your spouse's plan complete and sign the employer portion.

1. Member information (*refer to your ID card*)

Last name	First name	ID number

Address	Group/policy number

City	Province	Postal code	Phone number

2. Employer information

The following validates health/dental rates paid by the employee indicated above.
Extended health/dental plan rates paid by employee:

For the period of **YYYY-MM-DD** **to** **YYYY-MM-DD**
**this date must be on or before the signature date on the next line.*
Amount $

Name of authorized officer or plan administrator	Signature of authorized officer or plan administrator	Date (YYYY-MM-DD)

Name of employer

3. Employee consent and declaration

I certify that the information contained in this and other documents supporting this claim is complete and true. **By submitting this form, I understand that I am requesting payment be made for the above expenses in accordance with my HSA.** I accept full responsibility to ensure that all expenses incurred and submitted for payment from my HSA are allowable medical expenses as defined under the Income Tax Act. If unsure please visit the CRA's web site **www.cra-arc.gc.ca/medical** and/or call the CRA's *Individual income tax enquiry line* at **1-800-959-8281** for further information.

I certify that the individuals for whom this claim is made are eligible under my HSA and/or may include others defined as eligible dependants by the Income Tax Act (those who were financially dependent on me during the last taxation year and for whom I can claim a medical expense tax credit).

I understand that the personal information provided herein, as well as any other personal information currently held by Alberta Blue Cross about me and eligible dependants will be used to determine eligibility for this benefit, verify, assess and pay claims, and administer my HSA. I certify that I am authorized by my spouse and/or dependants to disclose and receive information about them that is used for these purposes. I hereby acknowledge and agree that the personal information may be exchanged between Alberta Blue Cross and a health care professional, practitioner, institution or health benefits provider or insurer when needed for a purpose stated above.

I understand that the personal information will be kept confidential and secure. I understand that I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered. I understand why the personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. I have read and understood this employee consent and declaration.

Signature of member (required)	Date (YYYY-MM-DD)

This consent is obtained in accordance with Alberta's Health Information Act, Alberta's Personal Information Protection Act and the federal Personal Information Protection and Electronic Documents Act.

SUBMIT ONLINE:
Sign in to your member site account at **ab.bluecross.ca** to upload this form, if this form was requested for verification.

SUBMIT BY MAIL:
Alberta Blue Cross
10009 108 Street NW, Edmonton, Alberta T5J 3C5