HEALTH SPENDING ACCOUNT CLAIM FORM

Please ensure that the drug name and **drug identification number (DIN)** appear on all drug receipts. This information is available from your pharmacist. Group your receipts, claim forms and/or Explanations of Benefits by family member and attach them to the back of this form. Receipts will not be returned. Your benefit statement is sufficient for tax purposes. **All statements must be completed or this form may be returned.** Submit your claim by:

Mail: **MDM Insurance Services Inc. P.O. Box #970, Guelph, Ontario N1H 6N1**
E-mail: **inquiry@mdm-insurance.com** Fax: **519-836-4909**

Privacy Statement
MDM Insurance Services Inc. ("MDM") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

Employee's Statement (Print clearly or type)

Name of Employer _____ Group Policy No. _____

Employee's Name _____ Date of Birth _____
Last First

Employee's Home Mailing Address _____
No. & Street Suite/Apt. No. City/Town Province Postal Code

Patient Name(s)	Relationship to Employee	Date of Birth Yr/Month/Day	If child 19 or older: Student Yes	Student No	Employed Yes	Employed No	Handicapped Yes	Handicapped No	If Student Indicate Name of Educational Institution

If your spouse has a benefit plan, all claims (whether for yourself or your dependents) should be sent to that plan for initial consideration. Expenses submitted attached to this claim form will be considered under your Health Spending Account regardless of standard Co-ordination of Benefits guidelines.

If any of the expenses have been paid or partially paid under any other plan (e.g. WSIB, Spouse's Employer, etc.), please include a copy of the benefits statement.

I certify that the information contained herein is true, complete and accurate and that each of the attached expenses was purchased and/or incurred in connection with medical treatment for me or my spouse and/or dependents. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. I authorize any physician, dentist or any health care provider and/or facility, any insurance company, benefit service provider and any other person or organization having any medical or other relevant personal information regarding me or my spouse and/or dependent(s) to release to and exchange with MDM, the group plan administrator or their representatives and/or agents any and all information necessary to investigate and confirm the accuracy and validity of this claim, determine eligibility for benefits and/or administer the claim and group benefit plan.

I understand that expenses for which I am reimbursed under my Health Spending Account cannot be claimed for Income Tax Purposes (except in Quebec where special rules apply). I also acknowledge that the persons for whom I am making a claim are eligible and include myself, my spouse, and any dependents for whom I am eligible to claim a medical expense tax credit as defined in the Income Tax Act. I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes. I also understand that my plan sponsor may have access to a summary of the total amounts claimed by me under my Health Spending Account for the purposes of tax or administrative reporting.

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 underwriting, administration and adjudicating claims. I confirm that my spouse and/or dependents, if any, also authorize MDM Insurance Services Inc. to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing my group benefits plan.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Date: _____ Signature of Employee _____