Manulife

Group Benefits
Taxable Spending Account Claim

This form is to be completed by the plan member.
Receipts must be attached for all expenses. (Please attach to the back of this form.)
Please retain copies for your files as receipts will not be returned.

1 Plan member information

Plan contract number _____ Plan member certificate number _____

Plan sponsor _____

Plan member name (first, middle initial, last) _____

Date of birth (dd/mmm/yyyy) _____ Daytime phone number ( ) _____

Plan member address (number, street and apt.) _____

City/Town _____ Province _____ Postal code _____

2 Claimant information

Complete for all expenses.
Use one line per patient.

Claimant's name	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Description of expense(s)

3 Claims confirmation

Total amount of ALL receipts submitted $ _____

NOTE - ORIGINAL RECEIPTS must be provided for all expenses.

4 Authorization and consent

By submitting a claim to Manulife, I confirm that I understand and agree to all of the following:

I certify that the information provided for the claim(s) being submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all goods or services as claimed and represent no duplication of claims previously submitted to other plans. **I understand and acknowledge** that submission of a claim determined by Manulife to be false or misrepresented will be reported, together with any related information/documentation, to my plan sponsor. **I understand and acknowledge** that Manulife may refer any claims it has determined were falsely submitted to law enforcement authorities for possible prosecution. Manulife will pursue the recovery of any money that has been obtained improperly through false claim submission. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, club operators, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with Manulife, and/or its service providers, for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim (Purposes). **I agree** that my coverage may be denied or terminated because of my providing false, incomplete or misleading Information.

I agree to refund any monies or overpayments that I may owe to Manulife in accordance with the provisions of the Group Benefits plan with Manulife, and **I authorize** Manulife to deduct such monies from my future claims. **I authorize** Manulife to disclose to my employer benefit amounts paid from the plan for tax reporting purposes. **I understand** that eligible expenses reimbursed under the Taxable Spending Account ("TSA") are defined by my Plan Sponsor and determination for eligibility is wholly within my Plan Sponsor's discretion. **I understand** that eligible expenses reimbursed under the TSA will be added to my T4, by my employer, as taxable income in the year which the claim was incurred. **I understand** that reimbursement of these expenses represents a taxable benefit to me and I am responsible for payment of any income tax on these amounts. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy, facsimile or electronic version of this authorization shall be as valid as the original. **I understand** that Manulife's Privacy Policy is available at **manulife.ca/groupbenefits**, or from my Plan Sponsor.

I understand that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to my Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom I have granted access; and
- persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

PLEASE SIGN HERE

Signature of plan member _____ Date signed (dd/mmm/yyyy) _____

5 Mailing instructions

Please mail your completed claim form and receipts to the appropriate address:

If you live outside Quebec:

Manulife Group Benefits
Health Claims
PO BOX 1653
WATERLOO ON N2J 4W1

OR

If you live in Quebec:

Manulife Group Benefits
Health Claims
PO BOX 2580 STN B
MONTREAL QC H3B 5C6

PRINT

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