HEALTH SPENDING ACCOUNT (HSA)
CLAIM FORM

UNIVERSITY OF THE FRASER VALLEY
HUMAN RESOURCES

EMPLOYEE NAME: _____

EMPLOYEE NUMBER: _____ **PHONE NUMBER:** _____

Are benefits payable for your spouse or children under another medical program: ☐ YES ☐ NO

***ORIGINAL RECEIPTS ARE REQUIRED FOR EXPENSES NOT COVERED BY ANY INSURANCE COMPANY.**

All submitted claims must be a minimum of $250.00 unless the claim is for the balance of your account. Claims less than $250.00 may be submitted in March of each year, in order to submit expenses incurred within the fiscal.

Medical expenses eligible for reimbursement must FIRST be submitted to your extended health/dental provider and to your spouse's extended health/dental provider, if you have coverage under his/her plan. Please attach copies of statements from all insurance providers showing payments received or denied. (Please visit http://www.ufv.ca/hr/benefits/health-spending-account/ for more information)

Please list expenses below, indicating who incurred the expense and their relationship to you.

DATE	NAME	RELATIONSHIP	DESCRIPTION	AMOUNT

TOTAL = _____

I certify that the above information is correct and all eligible expenses have been submitted to the appropriate insurance providers prior to submitting this claim.

SIGNATURE: _____ **DATE:** _____