



<b>For Office Use Only</b>

## CONFIDENTIAL HEALTH CARE SPENDING ACCOUNT (HCSA) CLAIM FORM

- Please complete this form (both sides) and send it with your **original** claim receipts or **original** explanation of benefits statements to Health Care Spending Account, Employee Health Services, Human Resource Services.
- Health and dental expenses are eligible for payment from your HCSA if they are not covered by provincial health care or your group plans. They must also qualify as an eligible expense pursuant to the *Income Tax Act*.
- You are required to claim through your group plans and provincial health care before claiming through your HCSA.

### EMPLOYEE INFORMATION

LAST NAME		FIRST NAME	
ADDRESS		CITY	PROV   POSTAL CODE
PHONE NUMBER		EMPLOYEE IDENTIFICATION NUMBER (four digit number on pay advice)	
EMPLOYEE GROUP (CheckOne)			
<input type="checkbox"/> ATA <input type="checkbox"/> OOS <input type="checkbox"/> ECSSA <input type="checkbox"/> AUPE			

### HOW DO I CLAIM UNDER MY HEALTH CARE SPENDING ACCOUNT (HCSA)?

<ul style="list-style-type: none"> <li>➤ Complete this HCSA form and attach your <b>original</b> receipts or <b>original</b> explanation of benefits form(s). If benefits are coordinated, attach payment statements from both benefits carriers.</li> <li>➤ Payment request must be made for reimbursement to occur. HCSA reimbursement will be made on a trimester basis (after October, January, and April). Reimbursement claims cannot exceed the credits in your HCSA for the plan year.</li> <li>➤ Additional forms are available from the Human Resource Services website at <a href="http://www.hrs.ecsd.net/">http://www.hrs.ecsd.net/</a></li> </ul>
---

**HEALTH CARE SPENDING ACCOUNT (HCSA)  
CLAIM FORM (cont'd)**

**CLAIM SUBMISSION**

<b>HCSA Claim Detail</b>				
Expense Description	Date of Service MM / DD/ YYYY	Claimant's Name	Relationship to Employee	Amount Claimed
_____	___/___/____	_____	_____	\$ _____
_____	___/___/____	_____	_____	\$ _____
_____	___/___/____	_____	_____	\$ _____
_____	___/___/____	_____	_____	\$ _____
_____	___/___/____	_____	_____	\$ _____
_____	___/___/____	_____	_____	\$ _____
			<b>TOTAL</b>	\$ _____

**QUESTIONS?**

Questions regarding your Health Care Spending Account can be directed to [HCSA@ecsd.net](mailto:HCSA@ecsd.net)

**MAIL THIS FORM TO:**

Health Care Spending Account  
c/o Human Resources  
Catholic Education Services  
9807 – 106 Street,  
Edmonton, AB T5K 1C2

As a public body, Edmonton Catholic Schools is required to protect and control information in accordance with the **Freedom of Information and Protection of Privacy Act (FOIP)** which sets out rules as to the collection, use and disclosure of personal information. The personal information requested herein is collected and used solely to determine eligibility of this claim and to administer your health care spending account. Service providers may be contacted as necessary to verify the eligibility of claims. Personal information will be disclosed to only those employees of Edmonton Catholic Schools responsible for assessing your claim or administering your health care spending account.\*

If personal information about my spouse or dependents is required to assess this claim, I hereby acknowledge that I have obtained their consent prior to this disclosure for Edmonton Catholic Schools to collect, use and disclose such personal information as indicated above. I hereby certify that the above information given is true, correct and complete to the best of my knowledge.

\_\_\_\_\_  
**EMPLOYEE SIGNATURE**

\_\_\_\_\_  
**DATE**

\*Questions about the collection, use or disclosure of this information may be directed to the Freedom of Information and Protection of Privacy Coordinator for Edmonton Catholic Schools at 441-6000.