



GroupSource
Suite 200, 5970 Centre Street SE
Calgary, AB T2H 0C1

Lifestyle & Wellness Account Claim Form

Employee Information

Policy Number	Employer Name		Employee Identification Number
Last Name	Given Name	Name Commonly Used	
Apt. / House #	Street Address		Date of Birth ____ / ____ / ____ yyyy / mm / dd
City	Province	Postal Code	Daytime Tel. No./Evening Tel. No.

Detail of Claim and Claimant Information

Description of Claim (E.g. Gym Membership)	Claimant's Name	Relationship to Employee	Date of Birth			Amount
			yyyy	mm	dd	

Total	\$
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Please attach ORIGINAL receipts or Explanation of Benefits summary to this form.

Are benefits available under any other insurance program? Yes No

If "Yes", please attach a copy of the Explanation of Benefits from the other payer.

Employee Authorization and Declaration

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses were purchased and/or incurred in connection with the above-named individuals. I declare that the dependents for whom the expenses have been submitted, if applicable, meet the definition of an eligible dependent under my Lifestyle & Wellness Account. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. I authorize any benefit service provider and any other person or organization having relevant personal information regarding me, my spouse, and/or my eligible dependents to release to and exchange with the insurer, 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. I confirm that I am authorized to act on behalf of my spouse and/or eligible dependents for such purposes. I acknowledge that my plan administrator may receive summaries of dollar amounts incurred for administrative and/or tax purposes. **Any copy of this Authorization and Declaration shall be as valid as the original.**

Employee Signature _____	Date _____
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Please note: Original signature is required on each claim form.

GroupSource is committed to protecting the confidentiality, accuracy and security of the personal information it collects and uses in the course of conducting business.