Please send completed forms to:

Kechnie Benefits
447 Frederick St., 4th Floor
Kitchener ON N2H 2P4
T: 519 571-2020 | 866 710-7080
F: 519 571-2424 | 866 710-7888

HEALTH CARE SPENDING ACCOUNT CLAIM FORM

		Male	Female	
Employee Last Name	Employee First Name	Sex		Date of Birth (M/D/Y)
Employee Address				
Employer/Company Name				

I and/or my spouse have coverage through another group benefits plan. Yes ☐ No ☐
If yes, please include EOB (explanation of benefits) showing what has already been submitted and paid.

Your Health Care Spending Account is available to you for submitting expenses that are not eligible under your Group Benefit Plan or for unpaid balances due to co-insurance or deductibles. For any unpaid balance through a spouse's Insurance Carrier please include all applicable receipts. Please separate all eligible expenses by claimant and attach receipts.

Claimant's Name	Relationship To Employee	Date of Birth	Health Expenses	Dental Expenses	Date of Expenses	Amount

☐ Statement of Payment from Primary/Secondary Insurer included where applicable

☐ Receipts Attached

_____ _____

Employee Signature **Date**

For Kechnie Office Use Only:

Date Received:_____ Date Processed: _____ Adjudicator Initials:_____