BANFF CENTRE FOR ARTS AND CREATIVITY

HEALTH SPENDING ACCOUNT (HSA) AND PERSONAL HEALTH AND WELLNESS ACCOUNT CLAIM FORM

This form should be used to submit claims under Banff Centre's Health Spending Account (HSA) or Personal Health and Wellness Spending Account (Wellness Account).
For HSA claims, the CRA has published a list of eligible expenses which can be found at www.cra-arc.gc.ca/medical
For Wellness Account claims, please refer to the Banff Centre Information Sheet for eligible expenses
NOTE: Expenses submitted on this form will not be processed under your core health and dental plans. If you wish to submit your claim first through your core health and dental plan, please use the appropriate Alberta Blue Cross health or dental claim form.

1. Employee Information:

Surname	First Name		Banff Centre ID#
Address			Department
City	Province	Postal Code	Phone Number

Please indicate if you are choosing the HSA or the Wellness Account for the 19/20 Fiscal year: _____

ORIGINAL RECEIPTS: You must attach original receipts to this claim. If you have claimed these expenses under your Alberta Blue Cross Plan, you must attach a printed explanation of benefits from the plan and copies of the submitted receipts.

2. Claim Submission Details:

Date of Service YY/MM/DD	Expense Description	Amount Claimed	Is this claim for an eligible dependent? Y/N

Only under the HSA, you may claim for dependents who meet Canada Revenue Agency (CRA) definition of eligible dependents for tax deduction purposes.

3. HSA Claim Dependent Details (if applicable):

Dependent Name	Relationship to Employee	I certify this is an eligible dependent under the Income Tax Act Signature:

4. Employee Declaration:

I certify that the information contained in this and other documents supporting this claim is complete and true. By submitting this form, I understand that I am requesting payment be made for the above expenses in accordance with the HSA or Wellness Account rules. I accept full responsibility to ensure that all expenses incurred and submitted for payment from my HSA are allowable medical expenses as defined under the Income Tax Act.

Signature of Employee:	**Date:**

For Pay and Benefits Use Only:

Date Claim Received	HSA or PHWSA Claim	Eligible Y/N	If claim denied, state reason	
Balance Available	Balance Applied	Balance Remaining	Entered for Reimbursement	Date of Reimbursement

Submit this completed and signed form along with original receipts to
Pay and Benefits, Human Resources, Stn 19