VITAL
HEALTH SAVINGS PLAN

CLAIM FORM

Vers 0909

To: Vital Health Savings Plan

Fax: 416 498-8004 or E-Mail: CNickle@vitalbenefitplan.com

No. of Pages (including cover):

INDIVIDUAL COVERED (VHSP BENEFICIARY)				
NAME			VHSP ACCT NO.	ASO ACCT NO.
ADDRESS (*Claim cheques will be sent to this address. Please PRINT clearly.*)			NAME OF BUSINESS/EMPLOYER	
City	Prov	Postal Code	Telephone B: H:	

ELIGIBLE CLAIM DETAILS ***Please attach receipts or other documents showing nature of expense and proof of payment. If insufficient room, please attach separate list and record total below.***

NAME OF PATIENT	TYPE OF EXPENSE	DATES	AMOUNT
		TOTAL CLAIMED	

Claims are processed upon receipt and reimbursed once payment by Plan Sponsor has cleared, subject to a minimum reimbursement amount of $100. Outstanding reimbursements below this amount will be paid at the end of the Plan year. If and only if Plan Sponsor and Claimant are the same person, Vital reserves the right to set off claim reimbursements against outstanding premiums.

CERTIFICATE and AUTHORIZATION

I certify that this claim includes only valid health care expenses eligible under section 118.2 (2) of the Income Tax Act (Canada) that are paid in full, and that these amounts have not been and will not be reimbursed on any other claim sub-mission to a benefit provider or used for a personal medical tax credit. I authorize the release of any information in respect of this claim to the Administrator or its authorized agents and consent to the use of such information for the administration of benefits under this Plan and the provision of financial advice and related products to me and the VHSP accountholder.

DATE (dd/mm/yyyy)	SIGNATURE

Office Use

DATE REC'D	CLAIM NO.	VALIDATED AMT	PREM AVAIL.	AMT TOPROCESS	PROCS'D & INITIALS
					☐

PENDING AMT.	Inv. No.	PYMT METHOD	PYMT DATE & PYMT CONFIRMATION	REP NO.