gpm group benefits

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FLEXIBLE HEALTH CARE SPENDING ACCOUNT CLAIM FORM

Group No. **GPM User ID**

INSTRUCTIONS

Important : This form is to be used by employees to claim medical reimbursement. By providing this form, the employer and GPM are not admitting liability.

1. COMPLETE THE SECTIONS PARTICIPANT STATEMENT AND ITEMIZED RECEIPTS.
2. STAPLE ALL ORIGINAL RECEIPTS TO THE CLAIM FORM.
3. SIGN AND DATE THE FORM.

PARTICIPANT STATEMENT

Group Name

Participant's Family Name(s) / Participant's Given Name(s)

Date of Birth (d/m/yyyy)

Address (Civic No., Street Name, City, Province, Postal Code)

Phone No.

Participant's Email Address

Your Spouse's Family Name(s) and Given Name(s) if applicable

Spouse's Date of Birth (d/m/yyyy)

Are benefits provided for under any other group insurance plan? ○ No ○ Yes

Is the claim for a dependent child under the age 26? ○ No ○ Yes

Itemized Receipts

Family Name(s) / Given Name(s)	Relationship to Participant	Date of Birth (d/m/yyyy)	# Receipts

TOTAL amount of listed receipts

Number of receipts associated to **TOTAL** amount

DECLARATION AND AUTHORIZATION

By submitting your claim, you confirm that the information provided is accurate, precise and true. Any false information may result in the rejection of your claim. You authorize GPM and its representatives to: (i) Investigate all providers of goods or services and obtain all information relating to the goods sold and services provided; (ii) Collect information regarding the reimbursement request or the claim; (iii) Obtain, use and disclose personal information concerning you or the persons referred to in your claim, necessary for its due diligence to determine its veracity. Note that we will share information relating to a false declaration or fraudulent claim to the competent authorities as well as to the Policyholder. You also agree that the person to whom the request for information is addressed to, answers the questions submitted for the verification of your claim and our inquiry.

PARTICIPANT'S SIGNATURE

Date (d/m/yyyy)