HSAflex

Health Spending Account Claims Authorization

claims are subject to a $3.75 processing fee
claims under $100 also subject to $5.00 processing fee

Company Name of Employer

Employee's Last Name	First Name	Initials	○ Single ○ Family	Benefit Class

Employee Reimbursement for payment to the Employee	use only one line (below) to total all expense receipts if for the same claimant, and enter relation to employee		Amount of Claim including any tax
Last Name of Claimant	First Name	Relationship to Employee	Amount of Claim
	Sub-total:	**Reimbursement to Employee**	0.00

Service Provider Payment for payment to the Providers	use only one line (below) to total all expense receipts if for the same claimant and the same service provider		Amount of Claim including any tax
Last Name of Claimant	First Name	Name of Service Provider	Amount of Claim
	Sub-total:	**Payment to Service Providers**	0.00
	Totals:	**Employee and Service Providers**	0.00

Employee Authorization must be dated by Employee

date of signature

Employee Authorization must be signed by Employee

signature of eligible employee

Instructions for Submitting Claims		
Send Authorization, Receipts and Statements, by either:		
Fax	(855) 280-3295	Toll Free
Email	mailroom@assureflex.com	as PDF attachment
Mail	Post Office Box 81, Strathroy, Ontario N7G 3J1	
Retain Copies of Authorization, Receipts and Statements		