Quikcard

V2024042310

CLAIM FORM – For Wellness/Personal Spending Account

INSTRUCTIONS: Attach detailed receipts for all expenses, sign, and date form.	**COMPLETED FORM:** Can be mailed, faxed, or emailed to claims@quikcard.com.

1. Cardholder Information

Name	Group #	Certificate #	Date of Birth D/M/Y

Address	City	Province	Postal Code

2. Claim Details *(Please keep a copy of this form and receipts for your records)*

Date of Service (D/M/Y)	Expense Description	Amount Claimed

Eligible expenses vary according to coverage available under your group benefit plan. To find out whether an expense is eligible for coverage, please speak with your Plan Administrator. All reimbursed claims will be treated as a taxable benefit.

3. Disclaimers

PRIVACY NOTICE: The information requested in respect of this claim is required by Quikcard for benefits administration purposes. For these purposes Quikcard will, where necessary, collect from and exchange information with others. For more information, consult Quikcard's privacy policy or contact Quikcard by phone or mail.
AUTHORIZATION: I authorize for a period of not less than twelve and not more than twenty-four months from the date hereof, any employer, physician, practitioner, health care provider, hospital, health care institution, and any other medical or medically related facility, any insurance company, workers compensation board or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Quikcard, all personal health information or any other information or records in its possession that is requested while and for the purpose of administering this claim. A photocopy of this authorization shall be as valid as the original.
PRODUCTS OR SERVICES RECEIVED: I declare that the products or services listed on this claim have been received in full.
CLAIMANT'S STATEMENT: I declare that the information contained on this claim form is true and complete to the best of my knowledge and belief. I am authorized to provide and receive the personal information of my spouse and dependants to submit this claim and for benefits administration purposes and to give the authorization set out below on my own and any of their behalf.

Signature of Cardholder	Date