



**Covenant
Health**

**Flexible Benefit Program
Exempt / HSAA
Used Fitness Equipment Submission**

EMPLOYEE INFORMATION

Last Name		First Name and Initial		Alberta Blue Cross ID
Address				Group Number 22131
City	Province	Postal Code	Telephone Number	

CLAIMING INFORMATION

Used Fitness Equipment	
<input type="checkbox"/> Private sale Provider's name: _____	\$ _____
<input type="checkbox"/> Commercial Sale Provider's name: _____	\$ _____
Please ensure that all original receipts are attached	
Total Amount Claimed	\$ _____

AUTHORIZING TO SUBMIT PAYMENT

Employee signature: _____ Date: _____

Approved by (please print): _____ Phone: _____

Approval signature: _____ Date: _____

Approval signature from Covenant Health is required to process the claim.

Please forward the claim form with original receipts to the Benefits Department, 7R, Edmonton General Continuing Care Centre.

Employees: Please retain a copy for your records.