The Health Plan

Tax Effective Private Health Care For Canadians

Clear Form ON

Claim Submission Form

Policyholder

Name: **Contract No:**

_____

Claimant Information *

Surname: _____ **Given Name:** _____

Mailing Address: _____

_____

(city) (province) (postal code)

Telephone Number: (_____)_____ _____ **Fax Number:** (_____)_____ _____

*This is the name of the claimant to whom reimbursement will be made.

Expenses

Name of Claimant	Relationship to Employee	Date of Birth (mm/dd/yy)	Medical Charges

I authorize the release of any information requested in respect of this claim to The Health Plan or its subsidiaries, affiliates or agents and certify that the information is true, correct and complete to the best of my knowledge. I authorize the use of any of the claim information for the administration of the benefits under this Private Health Services Plan.

Total Expenses	$	0.00
8% Claim Administration Fee	$	0.00
Sub-Total (Expenses + Claim Admin Fee)	$	0.00
GST/HST (on Claim Admin Fee Only)*	$	0.00
2.0% Premium Admin (on-Total Expenses)	$	0.00
Total Payable to The Health Plan	$	0.00

Manual Numbers

Auto Numbers

_____

Signature

_____

Date (Day/Month/Year)

Please make all cheques payable to
The Health Plan Inc.

PO BOX 133, Station "A", Etobicoke, Ontario, M9C 4V2

GST#: 804622652

* GST applicable only in provinces that the Harmonized Sales Tax (HST) does not apply. Otherwise apply HST.