

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	\$.
8% Administration Fee	\$.
Sub-Total (Expenses + Admin Fee)	\$.
GST/HST (on Admin Fee)*	\$.
2% Premium Tax (on -Total Expenses)	\$.
Total Payable to The Health Plan	\$.

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.