



THE CLAIM FORM
(For Ontario Sole Proprietors Only)

PLEASE PRINT

COMPANY NAME

EMPLOYEE NAME

I.D. # OR SIN #

EMPLOYEE ADDRESS

CITY / PROVINCE / POSTAL CODE

DIRECT DEPOSIT - CURRENT DIRECT DEPOSIT INFORMATION MUST BE ON FILE WITH THE TRUST OR ATTACH A COMPLETED DIRECT DEPOSIT FORM)

PLEASE SEND MY CHEQUE TO THE COMPANY ADDRESS

PLEASE SEND MY CHEQUE TO THE ABOVE ADDRESS

ONLY OFFICIAL RECEIPTS MUST ACCOMPANY THIS FORM. RECEIPTS MUST CLEARLY INDICATE THE DATE OF SERVICE THE AMOUNT OF PURCHASE AND THE PATIENT NAME.

DATE OF SERVICE			EMPLOYEE NAME / DEPENDANT NAME	TYPE OF SERVICE	
MONTH	DAY	YEAR		I.E. MEDICAL / DENTAL	AMOUNT PAID
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Give this form to your plan administrator or mail to :

AVP Health & Welfare Trust
222, 855 - 42 Avenue SE
Calgary AB T2G 1Y8

Questions ?

Call : 403.214.3213 or 888.214.3211
Toll free Fax : 866.213.5514
E- mail : info@bizflex.ca
www.bizflex.ca

TOTAL CLAIMS	\$	<input type="text"/>
ADMIN FEE 10 % (OF CLAIMS)	+ \$	<input type="text"/>
GST 5 % (OF ADMIN FEE)	+ \$	<input type="text"/>
TOTAL EXPENSE	= \$	<input type="text"/>

FYI :
CLAIMS = EMPLOYEE'S OUT-OF-POCKET COSTS
EXPENSE = EMPLOYER'S AMOUNT PAYABLE (TO TRUST)