# THE CLAIM FORM

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 | | | | TYPE OF SERVICE | |
|---|---|---|---|---|---|
| MONTH | DAY | YEAR | EMPLOYEE NAME / DEPENDANT NAME | I.E. MEDICAL / DENTAL | AMOUNT PAID |
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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

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

| | | |
|---|---|---|
| TOTAL CLAIMS | | $ |
| ADMIN FEE 10 % (OF CLAIMS) | + | $ |
| GST 5 % (OF ADMIN FEE) | + | $ |
| TOTAL EXPENSE | = | $ |