

Claim Form - Ontario

FlexSave™

Company Name: _____

Employee Name: _____

Only original official receipts will be accepted. All receipts must clearly indicate the date, the amount of purchase including taxes, for whom the purchase was made and what item/service was purchased.

Date of Service dd/mmm/yyyy	Name of Claimant (your name / dependent's name)	Type of Expense (Health / Dental / Wellness)	Amount of Receipt

Total Claims	
Administration Fee 10%	
Subtotal	
HST on Administration Fee 13%	
PST 8%	
Premium Tax 2%	
Total	

Date: _____

DD/MMM/YYYY

Signature:  _____

