Claim Form - Atlantic Canada

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 15%	
		Total	

Date: _____
DD/MMM/YYYY

Signature: X _____

HUB

FlexSave™ Division – HUB Financial Inc. 1001, 3700 Steeles Avenue West, Woodbridge, ON L4L 8M9
Phone: 1 (800) 561-2405 (option 2) or Fax: 1 (866) 417-8394 | Email: flexsave@hubfinancial.com

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