Claim Form - Quebec

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%	
Sales 9%	
GST on Administration Fee 5%	
QST 9.98%	
Premium Tax 2.3%	
Total	

Date: _____
DD/MMM/YYYY

Signature: X _____

HUB

FlexSave™ Division – HUB Financial Inc. 1001, 3700 Steeles Avenue West, Woodbridge, ON L4L 8M9
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