

CLAIM FORM (Pay-As-You-Go)

Date: _____

Business Planholder Name: _____

Name of Covered Employee: _____

Employee Email Address: _____

Name of Payee: _____

(If different than Covered Employee)

Patient Name	Service Date	Description	Amount
Use a separate sheet or spreadsheet printout if necessary.			Total Claim: A
			Administration Fee (A x 5%): B
TAX (on Administration Fee Only)	GST	AB,SK,MB,PE,YT,NT,NU	(B x 5%):
	HST	BC	(B x 12%): C
	HST	ON,NB,NL	(B x 13%):
	HST	NS	(B x 15%):
			Total Fee Payable: (A + B + C)

Employee certifies that all health services were purchased by or for an eligible member of their household.

Signature: _____