BROCK
HEALTH ADMINISTRATION LTD.

BBB ACCREDITED BUSINESS

CLAIM FORM (Pay-As-You-Go Plans)

Date: _____

Business or Company Name: _____

Name of Covered Employee: _____

Employee Email Address: _____

Patient Name	Service Date	Description	Amount
Use a separate sheet or spreadsheet printout if necessary. If using multiple pages, please carry forward Total Claim Amount to last page.		Total Claim: **A**	
		Administration Fee (**A** x 5%): **B**	
TAX (on Administration Fee Only) GST BC,AB,SK,MB,YT,NT,NU (**B** x 5%):			
HST ON (**B** x 13%): **C**			
GST/HST No. 83077 8924RT0001 HST PE (**B** x 14%):			
HST NS,NB,NL (**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: _____