



**THE CLAIM FORM
(For BC Only)**

PLEASE PRINT

COMPANY NAME

EMPLOYEE NAME

I.D. # OR SIN #

EMPLOYEE ADDRESS

CITY / PROVINCE / POSTAL CODE

DIRECT DEPOSIT (CURRENT DIRECT DEPOSIT INFORMATION MUST BE ON FILE WITH THE TRUST OR ATTACH A COMPLETED DIRECT DEPOSIT FORM)

PLEASE SEND MY CHEQUE TO THE COMPANY ADDRESS

PLEASE SEND MY CHEQUE TO THE ABOVE ADDRESS

ONLY OFFICIAL RECEIPTS MUST ACCOMPANY THIS FORM. RECEIPTS MUST CLEARLY INDICATE THE DATE OF SERVICE THE AMOUNT OF PURCHASE AND THE PATIENT NAME.

DATE OF SERVICE			EMPLOYEE NAME / DEPENDANT NAME	TYPE OF SERVICE	AMOUNT PAID
MONTH	DAY	YEAR		I.E. MEDICAL / DENTAL	
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mail to : AVP Health & Welfare Trust
222, 855 - 42 Avenue SE
Calgary AB T2G 1Y8

Questions ?
Call : 403.214.3213
Toll free Fax : 888.214.3211
email info@avpbizflex.com
www.avpbizflex.com

CLAIMS \$ _____

Add: Admin Fee (10% of claims) \$ _____

Add: HST (12% of admin fee) \$ _____

TOTAL EXPENSE \$ _____

FYI :
CLAIMS = EMPLOYEE'S OUT-OF-POCKET COSTS
EXPENSE = EMPLOYER'S AMOUNT PAYABLE (TO TRUST)