



**THE CLAIM FORM**  
**(For Ontario 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	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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  
E- mail : info@bizflex.ca  
www.bizflex.ca

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

TOTAL CLAIMS	\$	<input type="text"/>
ADMIN FEE 10 % (OF CLAIMS)	+	\$ <input type="text"/>
SUB - TOTAL (OF CLAIMS + ADMIN)	=	\$ <input type="text"/>
GST 5 % (OF ADMIN FEE)	+	\$ <input type="text"/>
PST 8 % (OF CLAIMS + ADMIN)	+	\$ <input type="text"/>
PREMIUMTAX 2 % (OF CLAIMS + ADMIN)	+	\$ <input type="text"/>
TOTAL EXPENSE	=	\$ <input type="text"/>