PHSP (Cost Plus) Health Claim Form

PACIFIC EMPLOYEE BENEFITS

Please send claims to:

PO Box 3249, 3756 First Avenue, Smithers,BC   V0J 2N0

Instructions: Attach the bills, original receipts and Dental claim forms for dental,for all expenses and itemize them by providing all the information requested. Note: Drug bills
receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization or exp
that will accompany our cheque for Income Tax Purposes. Please note, the Income Tax Act dictates the guidelines as to what benefits are eligible for reimbur

Important: Please answer all questions. This claim may be returned to you if it is incomplete or contains errors.

Please Print

Employee's Statement

Group Number	Certificate Number	Employer Company Name	
Employee Name		Phone Number	
		Home: Work:	
Mailing Address			
City	Province	Postal Code	Email Address

Please indicate if this is a new address to be updated in the system: Yes_____   No_____

Claim Details

	*Please indicate dental and medical claims in separate entries. If additional space is needed, attach a separate page		
Patient Name:	Number of Receipts:	Type of Expense(s):	Total Charge:
Total amount submitted for reimbursement:			

A.   Total Claim Amount   _____

B.   Service Charge (10% with a minimum of $5.00)   _____

C.   GST on Service Charge (B. x 5%)   _____

D.   Total Amount   _____

*If enclosing payment with claim, please make cheque avaliable to Pacific Employee Benefits Ltd

I certify that I and/or my dependents incurred these expenses and that the information given is true, correct and complete to the best of my knowledge and that the attached receipts represent a expense that is medically necessary. I authorize Pacific Employee Benefits, healthcare providers, insurance or reinsurance companies, administrators of benefits programs, other organizatoins and service providers to exchange personal information, as necessary, for the adjudication of the claims I submit and the administration of the benefit program. I understand that the personal information will be kept confidential and secure. I have read and understand this Member consent and Declaration.

Signature of Employee   _____   Date   _____

Oct-15

For Office Use Only	Processed by:_____
Payment included with claim? Yes _____ No _____	
If no: Date invoiced: _____	
Payment recived: _____	