**Personalized Health Care Plans For Canadian Small Business**
**~No Monthly Premiums~**

# Employee Claim Form

| | |
|---|---|
| **Employer:** | |
| **Employee Name:** | |
| **Employee #:** | Claim # Office Use Only |

| Item # | Date of Expense | Patient Name | Type of Expense | Amount |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| | | | Total Claims | |
| | | | Administration Fee-10% | |
| | | | GST-5% of Admin. Fee | |
| | | | **TOTAL DUE** | |

**Please complete all areas, including your signature below. Return this form with ALL original receipts and a cheque for the total amount due to:**

Heartland Medical Ltd.
203-304 Main Street Square, Suite 333
Airdrie, AB T4B 3C3

I hereby authorize the release of any information or records of this claim to the plan administrator and certify that the information given is true and correct to the best of my knowledge.

**Employee Signature:**_____ **Date:**_____