Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

# Benefit Claim Form
# Cost Plus Account

**Send to:**
Email: claims@healthrisk.ca
Fax: (403) 236-9420
Mail: 50, 12221 - 44th Street SE
Calgary AB T2Z 4H3

## 1. EMPLOYEE INFORMATION

| | | |
|---|---|---|
| **Employee Full Name:** | **Sex:** ◯ Male ◯ Female | **Date Of Birth:** (mm/dd/yyyy) |
| **Company Name:** | | |
| **Company Address:** | | **Group Number:** |
| **City:** | **Province:** | **Postal Code:** |

Please separate all eligible expenses and totals by claimant. Attach eligible receipts.

## 2. CLAIM INFORMATION

| Name of Claimant | Relationship to Employee | Date of Birth (mm/dd/yyyy) | TOTAL Medical Charges | TOTAL Dental Charges |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | **Total:** | | |

| | |
|---|---|
| **A. Total Claim Amount** | $ |
| **B. Administration Fee *** | $ |
| **C. Subtotal (A + B)** | $ |
| **D. GST on Administration Fee (B x 5%)** | $ |
| **E. Total Amount Enclosed (C + D)** | $ |

## 3. CONSENT AND SIGNATURE

I consent to the collection, use and disclosure of my personal information for the purposes of communication, underwriting risks, investigation and adjudication of claims, detection and prevention of fraud, compiling of statistics and acting as required and authorized by law. I also authorize my plan sponsor to this same information for benefits administration and to make any necessary payroll deductions which may be required.

| | | |
|---|---|---|
| **Name of Authorized Person:** | **Signature:** | **Date:** |

*Administration Fee is 10% of Total Claim Amount with a minimum charge of $25.00
Signature and Original receipts required with submission.