

**COST PLUS CLAIM FORM**



Forward claims to: THE BENEFITS TRUST

3800 Steeles Avenue West, Suite 102W, Vaughan, Ontario L4L 4G9 Phone: 905-264-8990, 1-800-487-2993

Your Name: \_\_\_\_\_ Your Certificate Number: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Unit: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Employer: \_\_\_\_\_ Contract Number: \_\_\_\_\_

**Employee Authorization**

I hereby certify that the above information is true to the best of my knowledge and that these expenses were incurred by myself (or my dependants) for the exclusive use of the person for whom the expense was incurred, as indicated above. I authorize The Benefits Trust and its administrators to use my social insurance number for identification purposes in the handling of my claim. In addition, I also authorize my Employer and The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Claim Form and any other benefit related information contained in files regarding me or my dependents, now or in the future, for the purposes of administration and/or management of the Benefit Services Contract issued by The Benefits Trust. A photostatic or facsimile or carbon copy of this authorization shall be as valid as the original.

Signature of Covered Employee: \_\_\_\_\_

Date: \_\_\_\_\_

**Claim Instructions**

List and total expenses on the reverse side of the claim form. Transfer the Total Claims to line (A).

<b>(A) Total Claims</b>		<b>(A) \$</b> _____
<b>(B) Add 10% Administration fee</b>	(A) x 10%	<b>(B) \$</b> _____
<b>(C) Subtotal</b>	(A) + (B)	<b>(C) \$</b> _____
<b>(D) Add 2% premium tax</b>	(C) x 2%	<b>(D) \$</b> _____
<b>(E) Add 8% PST</b>	(C) x 8%	<b>(E) \$</b> _____
<b>(F) Add 5% GST on Admin + Premium tax</b>	(B + D) x 5%	<b>(F) \$</b> _____
<b>(G) Total claims amount + expenses</b>	(C) + (D) + (E) + (F)	<b>(G) \$</b> _____

**Please make your cheque for the total amount in (G) payable to The Benefits Trust.**

**Employer Authorization**

The employer is hereby authorizing payment of this Cost Plus claim. All receipts are attached to this claim form, along with a cheque from the employer for the total claim amount plus administration fees and taxes. Please return the reimbursement cheque to:

Employee's home address

Employer's address

Authorized Signature: \_\_\_\_\_

Date: \_\_\_\_\_

