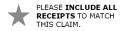
## **Employee Claim Submission Form**



Company Name Reimbursement for Employee Middle Initial Last Name First Name Update my e-mail address **Claim Details Date Claim Occurred Patient Name** Type of Claim Amount of Claim \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ **Prescription Drug Claims** Line 1 **Dental Claims** Line 2 Vision Care Scan and email your receipts Line 3 for faster processing! Paramedical Claims Line 4 Health & Dental Premiums Line 5 Other Health Claims Line 6 Total Claim (Lines 1 - 6) Line 7



IF YOU HAVE NOT DONE SO ALREADY PLEASE FAX, MAIL OF SCAN A VOID PERSONAL CHEQUE FOR ELECTRONIC CLAIM REIMBURSEMENT