Employee Claim Submission Form

PRIVATE HEALTH SERVICES PLAN

Company Name ______________________________

Reimbursement for Employee ______________ ______________ ______________
Last Name | First Name | Middle Initial

Update my e-mail address ______________________________

Claim Details

Date Claim Occurred	Patient Name	Type of Claim	Amount of Claim
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$

Scan and email your receipts for faster processing!

Line 1	Prescription Drug Claims	$ ______
Line 2	Dental Claims	$ ______
Line 3	Vision Care	$ ______
Line 4	Paramedical Claims	$ ______
Line 5	Health & Dental Premiums	$ ______
Line 6	Other Health Claims	$ ______
Line 7	**Total Claim** (Lines 1 - 6)	$ ______

★ PLEASE **INCLUDE ALL RECEIPTS** TO MATCH THIS CLAIM.

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

Submission of this claim certifies that I have not and will not receive reimbursements from any other sources for this claim.

PUHL / PRIVATE HEALTH SERVICES PLAN

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