PO Box 423
Nobleford, AB T0L 1S0
(587) 352-9935
info@smartinbenefits.com

Smartin Benefits Plan Claim Form

A: Employee Information (Plan Member)

Plan Member Number (99-9999-999)

		-					-			

Today's Date (YYYY-MM-DD)

Company Name (Plan Owner)

First and Last Names (Plan Member)

Province (for Tax Calculation)

Note: If you email or mailing address (or any other information) has changed, please inform us immediately.

B: Claim Details

#	Expense Date	Patient Name	Claim Description	Amount
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				

Note: Please use a new form if more lines are required.

By signing below, you certify that all health services have been purchased for an eligible member of household.

Signature: _____

Total Claim Amount : A	
Administration Fee (A x 5%) : B	
GST/HST on Admin Fee Only (B x Tax%) : C	
Total Payment Amount (A + B + C) : D	

C: Next Steps

Important: Please number each receipt with the corresponding line number as on the claim form and send the (1) completed claim form, (2) all **ORIGINAL or COPIES of receipts** and (3) a payment for **Total Payment Amount** (D) to:

Mail to: Smartin Benefits
PO Box 423
Nobleford, AB T0L 1S0

Email to: info@smartinbenefits.com

Queries: (587) 352-9935