HealthPlus Corporation
Claims Form

Employer Name & Address	
Employee Name	
Employee Address	**Same as above** ☐ **or:**

CLAIM DETAILS

Total Claims submitted				
Less any Employer limits or deductibles				
Net Employee claims				**A**
HealthPlus processing fee	**10% of A**			**B**
HST on processing fee	**13% of B**			**C**
Total Employee expense	**A+B+C**			**D**
Payable to HealthPlus Corporation	**D**			

Claims payable to Employee ☐ **Or Medical Practitioner** ☐

Medical Practitioner Name & Address (If required)

Employer Authorization: _____

Signature of Business signing officer **Date**

Retain copies of Claims and Receipts
Send originals and payment to HealthPlus Corporation
PO Box 219, Uxbridge, Ontario L9P 1M7