CLAIM FORM

(Please complete form in full)

Company Name Phone ( ) _____

Employee Name Phone ( ) _____

All receipts must be submitted with the claim.

Patients Name	Category (Vision, Dental, Health)	Total Claimed Amount

Subtotal	$
Administration Fee	$
GST/HST (On Admin Fee only)	$
Total	$

Signature	Date

Claims can be emailed to: claims@DHCadmin.com

DHC Administrators Inc.
Phone: 403.912.4395 Toll Free: 1.877.912.4395 Fax: 403-948-1452

www.dhcadmin.com