THE EMPLOYMENT BENEFIT PLAN

Div of Elite Business Services Ltd.

SUMMIT A CLAIM

* Must be a minimum of $ 50.00

Date: * (MM/DD/YYYY)		Level *:
Employers Name: *		Employers Phone #:
Employees Name: *		Phone #:
Address:		
City:		Postal Code:
Claims submitted via this form constitutes consent to continue to contact you/your business by email.		

NOTE: ELIGIBLE RECIEPTS MUST BE SUBMITTED TO SUPPORT YOUR CLAIM

Date	Description of Expense	Patient	Amount
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
		Total Claim	$
		Administration Fee 5%	$
		GST / HST	$
		Total	$

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