MediDirect®
The Health, Dental & Wellness Benefit Program

CLAIM FORM

EMPLOYER AND EMPLOYEE INFORMATION

Employer Name: ABC Company Ltd.

Employee Name: John (First Name) B. (Initial) Smith (Last Name) Date of Birth (M/D/Y): 06/30/1970

Address: 123 Any Street Telephone: Res. (555) 555-5555

City or Town: Any Town Telephone: Cell. (555) 555-5555

Province: Any Province Postal Code: X1X 1X1 Email Address: johnsmith@sample.com

CLAIM INFORMATION

Claims must be accompanied by original receipts. Cash, debit or credit card receipts, or cancelled cheques are not acceptable as a substitute for a proper receipt. Please retain copies as original receipts will not be returned.

For Practitioner or Paramedical expenses (eg., chiropractor, massage therapist, physiotherapist) please attach an itemized statement or receipt stating patient name, practitioner name, type, licence and/or registration number, date of service, and charge for treatment. For equipment and appliance expenses, please attach a written recommendation from the prescribing physician, including diagnosis.

Date (M/D/Y)	Patient Name	Description of Item or Expense	Amount
1-31-2009	John Smith	ABC Optometrists - Eye Exam	$ 70.00
2-24-2009	Jane Smith	ABC Dentists - Examination	$200.00
6-1-2009	Bobby Smith	ABC Pharmacy - Prescription	$ 43.00
9-25-2009	Stephanie Smith	ABC Pharmacy - Prescription	$ 62.00

SAMPLE

Claim Amount	$375.00
Administration Fee (10% of Claim)	$ 37.50
Sub Total	$412.50
GST (5% of Administration Fee)	$ 1.88
☑ Ontario Employers Only: RST (8% of Sub Total)	$ 33.00
TOTAL	$447.38

Please make cheques payable to:
MediDirect® Inc. - In Trust
Attach original receipts to form and send to
MediDirect® Inc.
P.O. Box 1710, Station M, Calgary, AB T2P 2L7
Phone: (403) 537-6298 • Toll Free (866) 234-5162
Fax (403) 539-5511 • www.medidirect.ca

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