1900, 10104 - 103 Ave NW
Edmonton, AB T5J 0H8

COST PLUS (AB)
CLAIM FORM

Payment provided through **the Cost Plus plan.** Please note the Income Tax Act provides guidelines as to what benefits are allowed under this type of plan.

		Male Female	
Employee Last Name	Employee First Name	Gender	Date of Birth (M/D/Y)

Employer/Company Name	Daytime Phone Number

Please attach all **original** receipts, attach to the completed form and mail to Strive Insure. Claims which are faxed or emailed will be rejected.

Name of Patient	Relationship to Employee	Date of Birth	Health/Vision	Dental
		Subtotal:		

A. Total Claim Amount $ _____

B. Administration Fee (12% of "A") $ _____

C. G.S.T. on Administration Fee (B X 5%) GST No. 86783 9615 RT $ _____

D. Total Amount enclosed (A + B + C) $ _____

Employee Signature	Date (MM/DD/YYYY)

Phone: (780) 448-1637 Toll Free: 1-866-444-1637
www.striveinsure.ca