



**COST PLUS (ON)
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. H.S.T. on Administration Fee (B X 13%) HST No. 86783 9615 RT \$ _____
- D. P.T. on Administration Fee (B X 2%) \$ _____
- E. Total Amount enclosed (A + B + C + D) \$ _____

Employee Signature	Date (MM/DD/YYYY)
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