PO Box 423
Nobleford, AB T0L 1S0
(587) 352-9935
info@smartinbenefits.com

Smartin Benefits Plan Claim Form

A: Employee Information (Plan Member)

Plan Member Number (99-9999-999)

Today's Date (YYYY-MM-DD): 2021-11-08

Company Name (Plan Owner)

First and Last Names (Plan Member)

Please Select your Province (for Tax Calculation): <Select Province>

Note: If your email, mailing address or any other information changed, please notify our office immediately.

B: Claim Details

#	Expense Date	Patient Name	Claim Description	Amount
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Note: Please use a new form if more lines are required.

By signing below, you certify that all health services have been purchased for an eligible member of household.

Signature: _____

Total Claim Amount : A	0.00
Administration Fee (A x 5%) : B	10.00
GST/HST on Administration Fee (B x 0%) : C	0.00
Total Payment Amount (A + B + C) : D	10.00

C: Next Steps

Important: Please number each receipt with the corresponding line number as on the claim form.

Please include the following documents when submitting your claim:

1. This completed claim form
2. Clear copies of all receipts

Note: Please keep your original receipts.

Email to: info@smartinbenefits.com
Queries: (587) 352-9935

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