Fillable form

CLAIM FORM (British Columbia)

COMPANY NAME:	
EMPLOYEE NAME:	
SIGNATURE:	DATE:

Once completed please provide this form to your Plan Administrator to forward to HUB.

* Please note we strive to process all Direct Deposit claims within 10 business days and cheque within 15 business days

ONLY ORIGINAL OFFICIAL RECEIPTS WILL BE ACCEPTED. ALL RECEIPTS MUST CLEARLY INDICATE THE DATE, THE AMOUNT OF PURCHASE INCLUDING TAXES, FOR WHOM THE PURCHASE WAS MADE AND WHAT ITEM/SERVICE WAS PURCHASED.

DATE OF SERVICE	EMPLOYEE / DEPENDENT	DESCRIPTION OF EXPENSE Health / Dental / Vision	AMOUNT OF RECEIPT

Total Claims	$0.00
Administration Fee 10%	$0.00
Subtotal	$0.00
GST on Administration fee 5%	$0.00
Total	$0.00

HUB Use Only

Processor:		Less:	
		Receipts Missing / Copies only :	
Date Processed		Unprescribed / Ineligible Item :	
Cheque Number		Addition Error :	
Amount		**Edited Claim Amount :**	
		Contacted PA to advise - Date:	
		Phone ☐	Email ☐

FlexSave Division
HUB Financial Inc.
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