



Accerta Flex Remittance Form

Company Name: Dr.

Group Policy ID Number:

EMPLOYEE INFORMATION:

Employee's Name:

Address:

City:

ON:

Postal Code:

Amount Payable:

1) Total of Expenses being Submitted (Attach copies of receipts and claim forms)	\$ -
2) Processing Fee 10% of (1) (Minimum of \$20.00)	\$ 20.00
3) Taxes	
a) HST (#882482615) 13% of (2)	\$ 2.60
b) Premium Tax 2% of (1+2)	\$ 0.40
c) Retail Sales Tax 8% of (1)	\$ -
4) Total Amount Payable	\$ 23.00

Date:

Plan Sponsor / Administrator Signature

Mail this completed form with:

- A Standard Dental Claim Form or Health Care Expense Form
- All appropriate receipts. Each receipt and claim form must show the service provider's unique ID number.
- A corporate cheque

Mail To:

**AccertaClaim Servcorp Inc.
Station "P", P.O. Box 310
Toronto ON M5S 2S8
1 (800) 505-7430**

Note:

- Payment of claims will be directly to the employee noted above.
- Each claim form must be signed by the patient or guardian for those under the age of 18.