



AccertaClaim Servcorp Inc.

# AccertaFlex Remittance Form

**Company Name:** \_\_\_\_\_

**Group Number:** \_\_\_\_\_

**EMPLOYEE INFORMATION:**

Employee's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

**Amount Payable:** (Double click on table below and insert amount of claim)

1) Total of Expenses being Submitted (Attach copies of receipts and claim forms)	\$0.00
2) Processing Fee 10% of (1) (Minimum of \$20 )	\$0.00
3) Taxes	
a) GST (# 882482615) - 7% of (2)	\$0.00
b) Premium Tax – 2% of (1+2)	\$0.00
c) Retail Sales Tax – 8% of (1+2)	\$0.00
4) Total Amount Payable	\$0.00

**Plan Sponsor/Administrator** \_\_\_\_\_  
Signature Date

**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.