



AccertaChoicePlus 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	\$0.00
(Attach copies of receipts and claim forms)	
2) Processing Fee 10% of (1)	\$0.00
(Minimum of \$20 : Maximum \$300)	
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.