

# Accerta Cost Plus Remittance Form

**Company Name:**

**Group Number:**

**EMPLOYEE INFORMATION:**

Employee's Name:

Address:

City:

Province:

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 Maximum \$300)	\$	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.