Claim Form - Atlantic Canada

HUB | FlexSave™

Company Name: _____

Employee Name: _____

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/services was purchased.

Date of Service dd/mmm/yyyy	**Name of Claimant** (your name / dependent's name)	**Type of Expense** (Health / Dental / Wellness)	**Amount of Receipt**

Total	
Claims Administration Fee 10%	
Subtotal	
HST on Administration Fee 15%	
Total	

Date: _____
DD/MMM/YYYY

Signature: X _____

HUB

FlexSave™ Division - HUB Financial Inc. 1001, 3700 Steeles Avenue West, Woodbridge, ON L4L 8m9
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June 2021