# Claim Form - British Columbia

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** |
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| **Total Claims Administration** | |
| **Fee 10%** | |
| **Subtotal** | |
| **5% GST on Administration** | |
| **Fee Total** | |

**Date:** _____
DD/MMM/YYYY

**Signature:** X _____

HUB

FlexSave™ Division - HUB Financial Inc. 1001, 3700 Steeles Avenue West, Woodbridge, ON L4L 8m9
Phone: 1 (800) 561-2405 (option 4) or Fax: 1 (866) 417-8394 | Email: flexsave@hubfinancial.com

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