NuCare
FINANCIAL

NUCARE HSA AND FLEX PLAN
CLAIM FORM

(Please Print)

Today's Date:

EMPLOYER INFORMATION

Company Name:		Employee Name:	
Address:		Business Phone No:	Business Fax No:
		( )	( )
P.O. Box:	City:	Province:	Postal Code:

CLAIM INFORMATION

DATE	EMPLOYEE/DEPENDENT	DESCRIPTION OF EXPENSE	AMOUNT PAID

SUB-TOTAL

ADMINISTRATION FEE (%)

GST ON ADMINISTRATION FEE (%)

TOTAL EXPENSES

Note: All claims must be submitted within 12 months of the date of service.

Please forward completed form along with all original receipts to your administrator or send to:

Attn: Claims Department
NuCare Financial Services Inc.
251 Consumers Road 12th Floor
North York, ON, M2J 4R3

By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate and does not contain a claim for any expense previously paid for by this or any other plan. I certify that all goods or services being claimed have been received by me, and/ormy spouse and/or dependents. I understand that the information provided by me to NuCare Financial Services Inc. about myself and my dependants, will be used by NuCare Financial Services Incorporated for claims adjudication and any other services necessary in the administration of our health claim which may include the exchange of information with other parties to administer this health claim.

Name of Employee

Signature of Employee

Date