HOLDEN FINANCIAL SERVICES LTD.
PRIVATE HEALTH SERVICES ADMINISTRATOR

PHSP CLAIM FORM

Mail: Ensure you attach original receipts with form
Email: Scan and attach receipts with form to
claims@holdenfinancial.ca

PLEASE MAKE SURE THIS SECTION IS FULLY COMPLETED

COMPANY NAME	
EMPLOYEE NAME	

Member Name	Total Prescription Drugs	Total Dental	Total Eye Care/Vision	Total "Other" Medical Costs
TOTALS FOR EACH				

EMPLOYEE'S SECTION

IF you would like your claim paid directly into your bank account fill out the section below. If this is not filled out your claim will be paid by cheque mailed to your employer.

Pay Claim By EFT ☐ Pay Claim By Cheque ☐

Use New Banking (attach VOID cheque) ☐ Use Existing Banking ☐

Email address for confirmation of claim payment ________________________________
I authorize Holden Financial to deposit the proceeds of the attached claim into my bank account.
I understand that I must keep original receipts for 1 year and that Holden Financial may ask for the originals for auditing reasons.
Employee's Signature ___________________________________ Date ____________________

Employer's Section

Total Claim amount $______________ (Total for All Services)

Administration Fee $______________ (Total Claim Amount Plus Admin fee of %)

GST $______________ (5% of the Administration Fee)

Total Amount Due $______________ (GST # 879149821RT001)

We would like to pay: ________By Cheque attached
________EFT from our company account

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