BENEFITS CLAIM FORM

SHIELD MEDICAL INC

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Toll Free 1.888.606.0510
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11911-57 Street NW
Edmonton AB T5W 3V7

EMPLOYER

CLAIMANT

- The Claimant Name is the person to whom the cheque will be made payable
- To ensure prompt delivery of your claim cheque, please make any changes to your name, address etc by submitting a current Personal Data Sheet.

NAME OF INDIVIDUAL	SERVICE DATE mm dd yyyy	DESCRIPTION OF MEDICAL EXPENSE Name Of Provider	Type of Expense	AMOUNT CLAIMED

OUR GST #: 77270-7329

SUBTOTAL:	$ 0.00
10% ADMIN FEE:	$ 0.00
GST:	Included in Admin Fee
TOTAL CHEQUE:	$ 0.00

CERTIFICATION: I certify that the charges for the medical expenses listed on this claim and for which original receipts are attached are being claimed under the Private Health Services Plan provision of the Income Tax Act and that the expenses were incurred by myself, my spouse or one of my eligible household members.

AUTHORIZATION: On behalf of myself and my eligible dependents, I authorize my employers and Shield Medical Inc to exchange the personal information contained on this form or any other benefit-related personal information contained in their files. This authorization is given on the understanding that the information will be used solely for the purposes of administration and management of my Private Health Services Plan.

SIGNATURE OF EMPLOYEE

DATE

PLEASE NOTE: Complete this form and return it with the ***original*** expense receipts attached.This form must be dated and signed.

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