navancorp
smart benefits for smart people

navancorp PHSP Claim Form

A: Employee Information (Plan Member)

Plan Member Number (00-0000-000)

Today's Date (YYYY-MM-DD)

Company Name (Plan Owner)

Plan Member Name (First and Last)

Please Select Your Province

☐ NS ☐ NFLD ☐ PE ☐ NB

B: Claim Details and Description

#	Expense Date	Patient Name	Claimed Item Description	Amount
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

*Please use a new form if you require more lines

Total Amount Claimed:	$ 0.00
Administration Fee (10%):	0
HST On Administration Fee (15%):	$ 0.00
Amount Payable to **navancorp**:	$ 0.00

Signature: _____

By signing above, you certify that all claimed health services have been purchased for/on behalf of an eligible member of your household.

Remember to advise us of any change of address or email for plan members.

C: Claim Process

Please send **a)** the completed claim form, **b)** all original receipts and **c)** a cheque for the total amount payable to:

navancorp, PO Box 46, Navan, ON K4B1J3

Questions? Email us at info@navancorp.ca