navancorp

CLAIM FORM

A: Employee Information (Plan Member)

Plan Member Number (000-0000-000)

Today's Date (YYYY-MM-DD)

Company Name (Plan Owner)

Plan Member Name (First and Last)

Please Select Your Province

Plan Member Email Address

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				
13				
14				
15				
			Total Amount Claimed	$0.00
			Administration Fee	$0.00
			GST / HST on Administration Fee (%)	$0.00
			Provincial Premium Tax (%)	$0.00
			Amount Payable to **navancorp**	$0.00

C: Signature

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

Signature: _____

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

D: Claim Process

Please send the completed claim form to **claims@navancorp.ca**

Questions? Email us at info@navancorp.ca