RESET FORM

OPTIMAL MEDICAL BENEFIT ADMINISTRATIVE SERVICES

Employee Claim Form

3075 Fourteenth Avenue, Suite 221, Unionville, ON L3R 0G9 T 905-946-8444 F 905-946-8944 info@ombas.ca www.ombas.ca

A Private Health Services Plan as defined in S.248(1) of the Income Tax Act

1. Please attach original receipts showing the patient name, date of purchase, description of purchase and cost.
2. Eligible expenses are determined by the Income Tax Act and by Revenue Canada Interpretation Bulletins.
3. Please submit claims within the contract year.
4. Kindly itemize each expense and attach all ORIGINAL receipts.
5. If claim has already been partially covered by another Group Health and/or Dental Plan, you may only claim the amount that has not already been covered.

Full Legal Name of Company

Last Name | Initial | First Name

Job Title

Address

City | Province | Postal Code

Phone ( ) | Fax ( )

Email

Date of Birth (YYYY / MM / DD) | S.I.N.

Name of Patient	Relationship To Employee	S.I.N.	Date of Birth yyyy/mm/dd	Drugs	Vision	Dental	Other Health
Total							

I request reimbursement for the expenses listed above. I understand that expenses reimbursed by Optimal Medical Benefits Administrative Services Limited may not be claimed for Income Tax Purposes. I authorize Optimal Medical Benefits Administrative Services Limited to use my dependant's and /or my Social Insurance Number (S.I.N.) for record keeping and certificate identification purposes. I hereby authorize insurers and qualifying health professionals to release information requested by Optimal Medical Benefits Administrative Services Limited to verify this claim. I certify that the statements herein and attached are complete, represent no duplication of charges previously submitted and were incurred in accordance with the Employer's Contract.

Date _____ Employee Signature _____