TC Taylor & Associates Ltd

EMPLOYEE CLAIM FORM

Employer Name: _____ HBP #_____

Employee Name: _____

Please complete all areas, including your signature. Ensure all original receipts are included

Item #	Date of Expense	Patient Name	Type of Expense (*dental etc)*	Amount
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Total Claims $ _____.____

I hereby authorize the release of any information or records of claim to the TC Taylor & Associates Ltd and certify that the information given is true and correct to the best of my knowledge.

Employee Signature: _____ Date ____/_____/_____ *dd / mm / yyyy*

Your file will be confidentially kept at TC Taylor & Associate Ltd at 12 Arthur St S Elmira, Ontario N3B 2M5