CanHealth & Dental Plans Ltd.

Extended Health Claim Form

Employer Name: _____ Employee Group # _____

Employee Name: _____ Employee ID # _____

Address: _____

City _____ Province: _____

Postal Code: _____

Phone _____

Date of Birth: _____

Employee Signature _____ **Date** _____

Reimbursement : Mailed [ ] E-transfer [ ] Email: _____

Patient	Patient Date of Birth	Number of Receipts	Receipt Total

Total

Send Form to: CanHealth & Dental Plans Ltd.
PO Box 79
Enderby, BC V0E 1V0

PH : (250) 838-6848
Toll (866) 566-6848
Fax (250) 838-9562

Email claim and receipts to: info@healthanddental.ca