Can Health & Dental Plans Ltd.

# Extended Health Claim Form

Company: _____ Group: _____ ID: _____

Employee: _____ ❒ Male ❒ Female
First Name Initial Last Name

Address: _____

_____
City Province Postal Code

Phone #: (  ) _____

Date of Birth: _____
Day / Month / Year

Employee's Signature: _____ Date: _____

| Patient | Patient Date of Birth | Number of Receipts | Receipt Total |
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Total _____

Send Form to:

CanHealth & Dental Plans Ltd.
PO Box 79
Enderby, BC V0E 1V0

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