



Health Spending Account Claim *my* **FLEX**plan

Company Name: _____ Plan ID: _____

Employee Name: _____ ID Number: _____

Direct Deposit to A/C on File OR Send cheque to address on file (fee may be applicable)

Signature: _____

Date: _____

Only original official receipts will be accepted. All receipts must clearly indicate the date, patient, description of item or service that was purchased and the amount of purchase including taxes.

Date of Service	Patient Name	Description of Expense	Amount Claimed
Total Claim			

Send To:



In BC: TOLCO Financial Strategies
 4400 Parkwood Terrace
 Victoria, BC V8X 4Z8
 Fax: 403-231-8631
 eMail: claims@tolco.ca

In Alberta: TOLCO Financial Strategies
 Suite 410, 1100 8th Ave SW
 Calgary, AB T2P 3T8
 Fax: 403-231-8631
 eMail: claims@tolco.ca