



**FLEXIBLE BENEFIT PROGRAM (EXEMPT/HSAA)
TRAVEL CLAIM FORM
GROUP NUMBER: 22131**

NAME: _____

ALBERTA BLUE CROSS ID#: _____

PHONE # (this is mandatory): _____

DATE	POINT OF ORIGIN	DESTINATION	COURSE NAME	COURSE START DATE	KM

Total KM: _____

Employee Signature:	<ul style="list-style-type: none"> • Local Travel Cost @ \$0.505 per KM (except where collective agreement otherwise specifies) • Parking (attach receipts) 	\$ _____
Date:		\$ _____

Manager Approval _____ Title: _____

Date: _____

GRAND TOTAL \$ _____

I hereby certify that the travel expenses listed above were incurred on Covenant Health business and have not been previously claimed by me or on my behalf from Covenant Health or any other organization.

NOTE: Please attach original receipt to your Alberta Blue Cross Flexible Benefit Program Claim Form. A copy should be kept for your personal records.