



BENEFIT PAYMENT FORM

To Whom It May Concern:

I, _____, am the primary policy holder of the policy below.

Insurance Company: _____

Policy Number/ Information: _____

I request and authorize that all benefit payments for the attached claim(s), for myself and/or my dependants, be made directly to the office of Omni Health and Rehab Clinic. I have attached invoices and applicable information for the services they have provided that I, and/or my dependants have received.

Please make cheques payable to **OMNI HEALTH AND REHAB**, and mail directly to the address indicate below.

Thank you,

OMNI Health and Rehab
310 Main St. East Suite 108
Milton, ON
L9T 1P4

(Signature of policy holder)

(Date)