BENECO
Flexible Benefits for Business Owners

COST PLUS CLAIM FORM

339 Tuscany Estates Rise NW
Calgary AB, T3L 0C6
Ph: Paul at (403) 651-4345 or Sean at (403) 547-5236 Fax: (403) 547-3106
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Plan Number:

Employee Name:
(please print)

Mailing Address:
No. & Street Apt. No. City and Province Postal Code

Employer Name: **Email Address:**
(please print)

CLAIM INFORMATION

All claims must be supported by original documents. Receipts must indicate the date incurred, the person for whom the expense was provided, who prescribed or provided the service, and the nature of the service or supply. Unless otherwise specified, all claim cheques will be payable to the Employee, and mailed to his/her address as indicated above.

LIST OF EXPENSES

Each expense must be listed separately. If more space is required, please attach another page.

Name of Patient	Relationship to Employee	Date of Service Month / Day / Year	Health Expenses	Dental Expenses	Vision Expenses	Total Charges
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
THIS SECTION TO BE COMPLETED BY THE EMPLOYER						
Box 1	**Total Expenses**					$
Box 2	**Administration Fee of 10% (10% of Box 1)**					$
Box 3	**G.S.T. on the 10% (5% of Box 2)**					$
Box 4	**Total Due (add boxes 1, 2 & 3)**					$0.00

(please ensure cheque attached is based on this amount, made payable to BeneCo Inc.)

AUTHORIZATION and CERTIFICATION

Please fill in all areas and sign the completed form. Incomplete or incorrect claim forms will be returned and / or rejected and will result in a delay in reimbursement. I authorize the release of the above information and records submitted with this claim to BeneCo Inc., my employer and my employer's plan administrator or their agents. I certify that the information given is true to the best of my knowledge.

I certify that all claims listed above are for legitimate medical or dental expenses incurred by myself and / or my dependents. Further it is agreed and understood that the above submission adheres to the guidelines of Canada Revenue Agency (CRA) regarding acceptable medical or dental expenses (IT Bulletin 519R2). At no time in the future will I or my dependents hold BeneCo Inc. and / or my employer responsible for those expenses disallowed by CRA. I agree to reimburse BeneCo and / or my employer for any such disallowed expenses.

Please fill in all areas and sign the completed form. Incomplete or incorrect claim forms will be returned and / or rejected and will result in a delay in reimbursement.

Employee Signature ***(signature required by employee)*** **Date** ***(please date)***

At BeneCo Inc. confidential information is maintained in your contract file as well as personal and medical information. This personal information will not be provided to any third party without written prior consent.