

**CLAIM FOR MEDICAL/DENTAL
COST-PLUS BENEFIT PLAN**

Firm Name _____

Employee Name _____

Address for reimbursement _____

Patient Name	Relationship to employee	Charges
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
TOTAL AMOUNT REIMBURSED (A)		\$ _____
CAIPW FEE (B)		\$ _____
CHEQUE TO CAIPW ENCLOSED (A+B)		\$ _____

All receipts and a cheque for the total amount (X) are enclosed. Please make the reimbursement cheque payable to the employee _____ or to _____ (dentist etc.).

I agree to hold harmless CAIPW, it's Directors and employees, who accept no responsibility or liability for any damages, penalties or assessments of income tax that may arise from this claim.

Date _____, 20____

Signature of claimant

As an authorized representative of the above firm, I request that the expenses listed above be reimbursed on a cost-plus basis. I confirm that such expenses qualify as medical expenses under Section 118.2(2) of the Income Tax Act and are within the claimant's annual reimbursement limit.

Date _____, 20____

Authorized signature

Send claim and cheque to the address below.