CPA INSURANCE PLANS WEST
Plans designed exclusively for CPAs.

CLAIM FOR MEDICAL/DENTAL COST-PLUS BENEFIT PLAN

Firm Name: _____

Employee Name: _____

Address for Reimbursement: _____

City: _____ **Province:** _____ **Postal Code:** _____

Phone: _____ **Email:** _____

Patient Name	**Relationship to Employee**	**Charges**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Total Amount Reimbursed (A) $_____

CPAIPW Fee (B) $_____

Cheque to CPAIPW Enclosed (A+B) Total $_____

All receipts and a cheque for the total amount (A+B) are enclosed. Please make the reimbursement cheque payable to the employee (_____) or to _____ (Dentist, etc.).

I agree to hold harmless CPAIPW, its 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 address below.