costplus Private Health Services Plans

Claims Authorization

Company Name: _____

Employee Name: _____
Last First Intl.

Claim For: ☐ Self And/or ☐ Dependent(s): _____

_____

Employee Class: ☐ All Employees ☐ Other Class: _____

Payment: ☐ Reimburse Employee ☐ Payment to Service Provider

Type of Eligible Claim Submitted:
☐ Dental Care ☐ Health Care Including Drugs
☐ Vision Care ☐ Professional Counseling

Eligible Claim Amount:		1	$
Reimbursement Percentage:	☐ % of 1 =	2	$
Balance of Maximum (if any) Remaining:		3	$
Employee Reimbursement: (Lower of 2 or 3)		4	$
CostPlus Processing Fee:	10 % of 4	5	$
Employee Benefit Expense: (4+5)		6	$
Premium and Sales Tax:	10 % of 6	7	$
Payment to CostPlus: (6 + 7)		8	$
Add $5 to 8 if Reimbursement (4) is Less Than $100		9	$

Employer Certifies that Employees agree that a Claims Summary will be included in the Annual Renewal Report to the Employer

Employer Authorization: _____
Signature of Business Signing Officer

Retain Copies of Claims, Receipts, Invoices, and/or Statements Send ORIGINALS and Payment (8 or 9) To:	**CostPlus Corporation P.O. Box 28115 Oakridge London, ON N6H 5R2**