Plan Member Cost Plus Claim Form

Plan Sponsor Name: ______________________________ **Contract# (if known)** ________________

THIS SECTION TO BE COMPLETED BY PLAN MEMBER					
Plan Member First Name		Last Name		Middle Name	
Address To Mail Claim				Postal Code	
City		Province		Email	

Claim Receipts and or Claim Forms Must be Enclosed to prevent delay in the claims processing.

Claimant : Plan Member		Claim Type	Date of last claim (mm/dd/yy)	Total Charges	Eligible %	Approved Amount
Last Name	First Name	Dental			%	
		Health			%	
Plan Member Number		Vision			%	

Claimant : Dependent 1		Claim Type	Date of last claim (mm/dd/yy)	Total Charges	Eligible %	Approved Amount
Last Name	First Name	Dental			%	
		Health			%	
		Vision			%	

Claimant : Dependent 2		Claim Type	Date of last claim (mm/dd/yy)	Total Charges	Eligible %	Approved Amount
Last Name	First Name	Dental			%	
		Health			%	
		Vision			%	

Claimant : Dependent 3		Claim Type	Date of last claim (mm/dd/yy)	Total Charges	Eligible %	Approved Amount
Last Name	First Name	Dental			%	
		Health			%	
		Vision			%	

Claimant : Dependent 4		Claim Type	Date of last claim (mm/dd/yy)	Total Charges	Eligible %	Approved Amount
Last Name	First Name	Dental			%	
		Health			%	
		Vision			%	

THIS SECTION TO BE COMPLETED BY PLAN SPONSOR

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 any information or records of this claim to the plan administrator or its agents and to certify that the information given is true to the best of my knowledge.

Mail claims to: Imax Financial Services Ltd. #98 - 124 Sarsons Road Vernon, BC V1B 2T9.

I hereby authorize Imax Financial Services Ltd. to use the above listed personal information and attachments (if any) for the purpose of entering claims into their Solutions claims adjudication systems and communication of information related to the coverage of services described in this form and attachments (if any) to the named service provider or myself only.

Sub Total	
Admin Fee 10% of Sub Total	
GST 5% of Admin Fee	
Grand Total Payable to Imax	

Plan Sponsor Signature: X_______________________________________ **Date** ____________________