cost plus benefits.ca

Wealth Mastery Planners Ltd.

Employee Claim Form

Employer/Business: _____

Employee Name: _____ DOB: __/____/____ mm/dd/yyyy

Item #	Date of Expense	Patient Name	Type of Expense (dental, prescription, etc.)	Amount
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Total Claims: $_____

Please complete all areas, including your signature below.

Ensure all ORIGINAL receipts are included in order for your claim to be processed.

I hereby authorize the release of any information or records of claim to the plan administrator o/a costplusbenefits.ca In Trust, and certify that the information given is true and correct to the best of my knowledge.

Employer Signature: _____

Date: _____