

COST PLUS BENEFIT CLAIM STATEMENT

KECHNIE BENEFITS

Payment provided through Private Health Services Plan. Please note the Income Tax Act provide guidelines as to what benefits are allowed under this type of plan.

		Male	Female	
Employee Last Name	Employee First Name	Sex		Date of Birth (M/D/Y)
Employer/Company Name		Employer/Company Address (Street, City, Province)		Postal Code

Reimburse the Provider (i.e. Dentist etc.)? Yes No (if yes, please ensure to provide full name and address)

Dentist Name	Address
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Please separate all eligible expenses by claimant and attach eligible receipts:

Name of Patient	Relationship to Employee	Date of Birth	Medical Charges	Dental Charges
Total:				

- A. Total Claim Amount \$ _____
- B. **ADD:** Admin Fee (8% of Line A - min \$25.00 / max \$250.00) \$ _____
- C. Subtotal (A + B) \$ _____
- D. **ADD:** Provincial Tax (8% of Line C) \$ _____
- E. **ADD:** Premium Tax (2% of Line C) \$ _____
- F. Total Amount Enclosed (C + D + E) \$ _____

Name of Authorized Person	Signature of Person	Date
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Please forward cheque and claim form to:

