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IMAX SOLUTIONS

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			100 %	
		Health			100 %	
Plan Member Number		Vision			100 %	

Claimant : Dependent 1		Claim Type	Date of last claim (mm/dd/yy)	Total Charges	Eligible %	Approved Amount
Last Name	First Name	Dental			100 %	
		Health			100 %	
		Vision			100 %	

Claimant : Dependent 2		Claim Type	Date of last claim (mm/dd/yy)	Total Charges	Eligible %	Approved Amount
Last Name	First Name	Dental			100 %	
		Health			100 %	
		Vision			100 %	

Claimant : Dependent 3		Claim Type	Date of last claim (mm/dd/yy)	Total Charges	Eligible %	Approved Amount
Last Name	First Name	Dental			100 %	
		Health			100 %	
		Vision			100 %	

Claimant : Dependent 4		Claim Type	Date of last claim (mm/dd/yy)	Total Charges	Eligible %	Approved Amount
Last Name	First Name	Dental			100 %	
		Health			100 %	
		Vision			100 %	

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.

If authorized, this form and receipts can also be e-mailed to imax@shaw.ca or faxed to 1888 658-8625.

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.

Plan Sponsor Signature: X_____ **Date** 06/12/12