Regence Co-Op Advertising Reimbursement Claim Form

Agent Information

Agent Name: ____ **Agent #:** _____________- ________

Address: ____ **Phone #:** _______________________

____

____

____

Agency Name: ____

Co-op Payment Request: *All requests should be postmarked no later than 60 days from the time the advertising was invoiced.*

Publication Name	Advertisement Run Date(s)	Total Cost of Advertisement	Office Use Only

NOTE: *Paid invoice and original copy of advertisement must be included with 'Reimbursement Claim Form'.*