# Co-op Advertising Claim Form

CUSTOMER NAME: ______________________ Four-Digit ACCOUNT #: ______________

ADDRESS: ______________________ PHONE #: ______________

______________________ FAX #: ______________

*Submitted By:* ______________________ DATE Submitted: ______________

Reference #: ______________________

| DEALER NAME | Description of Media/Event | Recur. Claims[1] [ Y / N ] | DATE of Media/Event MM / DD / YY | Invoice Amount | Requested Co-op Amount | *Approved* Co-op Amount |
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| | | | | TOTAL Co-op Reimbursement | | |

[1] Indicate Y [Yes] for this column if ads recurring throughout the year have been submitted previously.

**Please note that if you purchase through a Distributor, you MUST submit to them for reimbursement.**

Or if you are a distributor or direct dealer, attach documentation and mail to:

ATTN: **Co-op Department**
CFM Corporation
2695 Meadowvale Boulevard
Mississauga, ON L5N 8A3
Phone: (905) 858 - 8010 ext. 8276
Fax: (905) 858 - 3966
Email: vomasas@cfmcorp.com

***ALL CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS OF THE INVOICE DATE TO QUALIFY FOR CREDITS***

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31/03/06