



## CO-OP Reimbursement Claim Form

DATE: \_\_\_\_\_

Name of person submitting claim: \_\_\_\_\_

Company Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Do you purchase direct?	YES	NO	Do you purchase through wholesaler?	YES	NO
-------------------------	-----	----	-------------------------------------	-----	----

Who is your wholesaler? \_\_\_\_\_

Explanation of advertising you are submitting: \_\_\_\_\_

---

---

---

---

---

**Attach the following:**

Paid invoice totals submitted: \$ \_\_\_\_\_

Copy of advertisement(s)

Copy of paid invoice(s)

Send copies of all supporting (PRE-APPROVED)  
advertising materials and invoices to:  
[michelle.anderson@water-right.com](mailto:michelle.anderson@water-right.com)

### OFFICE USE ONLY

Amount credited to account: \$ \_\_\_\_\_

Date credited: \_\_\_\_\_

Remaining balance: \$ \_\_\_\_\_