

Group Name: _____ **Group #:Number** _____

Important! Please read:

Use separate forms for each claimant and dependent. Copy receipts and bills on a sheet of 8 ½ x 11 paper, and include supporting documentation with each submission. (No staples, please.)

Please complete:

Insured's Name: _____ Birthdate: _____

E-mail Address: _____ Last 4 digits of SS#: _____

Claimant's Name: _____ Relationship to Insured: _____ Birthdate: _____

(1) Provider of Services	(2) Date Incurred	(3) Amount of Expense	(4) Amount Eligible for Payment Under Plan of Benefit*	(5) Amount Eligible for Payment under Plan (Col. 3 minus Col. 4)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
<u>Total Submitted:</u>				_____

**Include amounts paid or eligible for payment under any other health care plan or program, federal, state or government program, workers' compensation, or any other policy or health insurance.*

I certify that the above statements are true and hereby authorize any physician, hospital, employer, union, HMO, insurance company or prepayment organization to give the claims administrator any additional information required in connection with this Claim for Medical Reimbursement Insurance Benefits. A photocopy of this authorization shall be as valid as the original.

Date: _____ Signed: _____

Return the completed form to:

Please keep a copy for your records.

BeniComp Select
8310 Clinton Park Drive
Fort Wayne, IN 46825
Phone: (866)797-3343