BeniComp Select
Medical Reimbursement Insurance Claim Form

Group Name: _____ Group #:_____

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)
			Total Submitted:	

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

Please keep a copy for your records.