BeniComp Select
Medical Reimbursement Insurance Claim Form

Group Name: _____ Group #: _____

Important! Please read:

Use separate forms for each claimant and dependent. You must include supporting documentation with each submission. Copy receipts and bills on a sheet of 8 ½ x 11 paper, and include supporting documentation with each submission.

Insured's Name: _____ Birthdate: _____

Email Address: _____ Last 4 digits of SSN#: _____

Claimant's Name: _____ Birthdate: _____

Relationship to Insured: _____

(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 confirm that the premium expense being submitted is for an excepted benefit and is not for other types of coverage, including but not limited to the Base Plan, COBRA Continuation of the Base Plan, Medicare Part B and D, or Prescription Drug Plans.

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: _____

WARNING: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.