HEALTH INSURANCE MITIGATION FUND CLAIM FORM

RECEIPT MUST BE ATTACHED – SUBMISSION TO TREASURER’S OFFICE MUST BE RECEIVED WITHIN 30 DAYS OF PAYMENT OF CO-PAY.

Step 1: Your Information

Name: ___________________________________________

Mailing Address: ___________________________________________

_________________________________________

Co-pay incurred by □ subscriber □ dependent (provide name)____________________

Step 2: Circle your Plan

Rate Saver Plans
BCBS Network Blue HMO
BCBS Blue Care Elect PPO
Harvard Pilgrim HMO

Benchmark Plans
BCBS Network Blue NE HMO
BCBS Blue Care Preferred PPO
Harvard Pilgrim ChoiceNet HMO

Step 3: Circle the Co-pay To Be Reimbursed:

$150 Outpatient Surgical (max amount for all plans)

$250 Hospital Admission (max amount for all plans)

Step 4: Sign & Date the Claim Form

_________________________________________  ______________
Signature        Date

REIMBURSEMENTS WILL BE ISSUED WITHIN 30 DAYS OF RECEIPT OF COMPLETED CLAIM FORM.