

CLAIM FORM (for Group Employees)

Date: _____

Group Planholder Name: _____

Name of Covered Employee: _____

Employee Email Address: _____

Name of Payee: _____

(If different than Covered Employee)

Patient Name	Service Date	Description	Amount
Use a separate sheet or spreadsheet printout if necessary.			Total Claim:

Employee certifies that all health services were purchased by or for an eligible member of their household.

Signature: _____