Deductible Met Form

Instructions

1. Complete this form in its entirety.
2. Include proof from your health plan that verifies you and/or your covered family member(s) met the annual deductible for your plan and the service date for which it was met.
3. Submit (1) this completed form and (2) documentation of proof (an Explanation of Benefits (EOB) from your medical carrier showing that the deductible has been satisfied and the date it was met) to the fax number or address listed at the bottom of this form.

Personal Information	
Employee Name	
Employer Name	Employee ID Number

Deductible Details			
Date Deductible Was Met	Deductible Amount	Savings Account Name	Plan Year

Certification	
I certify that I have met the annual deductible in my health plan. I have attached accurate and valid documentation that shows the date my deductible was met.	
_____	_____
Signature	Date

Submission Instructions	
For fastest results, fax to: (443) 681-4602	Or mail to: Claims Department P.O. Box 622317 Orlando, FL 32862-2317

If you have any questions, please contact **Customer Service** at **833-881-8158.**