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 this completed form **and** 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**.			