

HOW TO REQUEST MEDICAL PLAN BENEFITS

1. Each time you have a **different** accident or illness, please complete a **new** claim form and answer questions 1 through 16A on the reverse side of this form.

Please provide a **separate** claim form for **each** member of the family.

If you wish the benefits to be paid **directly** to your doctor or provider of service, please sign item 16B. If you wish the benefits to be paid to you, leave 16B blank.

2. Please attach completely itemized bills for each separate claim.

ITEMIZED BILLS MUST INCLUDE:

Doctor's Name and Tax ID Number

Patient's Name

Date of Service

Condition Being Treated

Charge for Service

3. If you do not have itemized bills, your doctor must complete the physician or provider of service information (items 17-34).

4. For your convenience, you may wish to accumulate small bills relating to the **same** claim and submit them on a monthly or quarterly basis.

Send the request for benefits to:
Self Funding Administrators Corporation
Claim Center
Post Office Box 46511
Cincinnati, Ohio 45246

If you have any questions, please call:
Annapolis Area
(410) 757-4200
Outside of the Annapolis Area
800-424-8611