COLLEGE OF THE
Holy Cross

MEDICAL EXPENSE REIMBURSEMENT PLAN
CLAIM FORM FOR REIMBURSEMENT

SUBMIT TO SULLIVAN BENEFITS Fax: (508) 439-4197 or

Mail To:	Your Name:
Sullivan Benefits	_____
Attn: Leslie Schuster	Employee HC ID#:_____
33 Boston Post Road W, Suite 120	
Marlborough, MA 01752	

Please include proof of payment and a copy of the corresponding explanation of benefits with your claim form submission.

Date incurred	Service provider	Expense description IP or Day surg copay	Person for whom expense was incurred	Total paid

Total amount of copay(s) paid	*$*

For each eligible claim submitted a reimbursement check will be issued ($125 Inpatient copay, $50 Day surgery copay) to you by the College of the Holy Cross.

Employee's Signature: _____ Date: _____