

DEDUCTIBLE CREDIT FORM

Employee Name: _____

Employer Name: _____

Member ID # or Social Security #: _____

Please complete the section below for all family members who are applying for a deductible credit. Be sure to attach an Explanation of Benefits (EOB) from your prior group insurance plan that indicates the amount of the deductible that you and your family members have met to date.

Employee's Name: _____ ID #: _____

Amount Satisfied: _____

Spouse's Name: _____ ID #: _____

Amount Satisfied: _____

Dependent's Name: _____ ID #: _____

Amount Satisfied: _____

Dependent's Name: _____ ID #: _____

Amount Satisfied: _____

Dependent's Name: _____ ID #: _____

Amount Satisfied: _____

Dependent's Name: _____ ID #: _____

Amount Satisfied: _____

Please submit the enclosed form along with supporting documentation to:

Deductible Credit Center
P.O. Box 7081
Bridgeport, CT 06601-7081