

EMPLOYEE BENEFIT SOLUTIONS, LLC
47 Old Ridgefield Road, Wilton, CT 06897
1 877 274-9993

SUPPLEMENTAL CLAIM FORM

Please attach to your original itemized bill

Group No. _____ Employer _____

Employee Name and SS# _____

Full Name of Patient _____

If dependent is full-time student, state school _____

If claim is for accident, state how, when, and where _____

If covered by any other group plan, provide employer/group #/insurance carrier _____

Benefits assigned and payable to: Hospital Doctor Employee

Employee Signature _____ Date _____

If your address has changed, please provide new address on reverse