LEGAL SERVICES NYC
CIGNA OPEN ACCESS PLUS BASIC REIMBURSEMENT REQUEST FORM.

ABOUT THIS FORM - WHAT YOU NEED TO DO:

If you are enrolled in the CIGNA Open Access Plus Basic plan effective November 1, 2009, you are entotled to receive reimbursement for certain benefits. Specifically, your In-Network Deductible ($150.00 per employee or $300.00 per family); Hospital Co-pays, Out-of- Network Deductible; Out of Pocket maximums and Infertility treatments.

Please use this form to submit your proof of rembursement by following these instructions:
1. Complete the information on this form.
2. Submit the proof of payment. Examples of proof of payment include:
   An explanation of benefits [EOB] showing this amount incurred toward your deductible and/or co payment.

Fax your proof of payment, along with this completed form to USI Insurance Services at (610) 537-4087. Or Email to: gerard.lannigan@usi.com

YOU ARE NOT OBLIGATED TO FAX OR EMAIL ANY PERSONAL HEALTH INFORMATION. If you prefer, you can mail your completed form to: USI Insurance Services, 261 Madison Avenue, 5th Floor, New York, NY 10016 Attn: Gerard Lannigan. **To qualify for reimbursement, you must submit this form an proof of payment with 365 day of your date of service.**

If you have any questions, contact Gerard Lannigan at USI Insurance Services: (212) 842-3409.

YOUR INFORMATION

NAME: _____

NUMBER OF PAGES FAXED _____

MAILING ADDRESS: _____

_____

DAY TIME PHONE: _____ EMAIL ADDRESS: _____

REIMBURSEMENT INFORMATION

Indicate Check Mark	Total:	
☐	$	IN NETWORK DEDUCTIBLE ($150 PER PERSON/$300 PER FAMILY)

Indicate Check Mark	Total:	
☐	$	HOSPITAL CO PAY ($425 OUT OF $500)

Indicate Check Mark	Total:	
☐	$	OUT OF NETWORK DEDUCTIBLE UP TO $150 AFTER $350 MET PER PERSON UP TO $250 AFTER $750 MET PER FAMILY

Indicate Check Mark	Total:	
☐	$	OUT OF POCKET MAXIMUM (Out of Network Only) UP TO $300 AFTER $1,050 MET PER PERSON UP TO $650 AFTER $2,100 MET PER FAMILY

Indicate Check Mark	Total:	
☐	$	INFERTILITY TREATMENTS - EFFECTIVE 07/01/2013 ANNUAL MAXIMUM $25,000 PER PERSON (Lifetime maximum reimbursement is $50,000 per person)

Indicate Check Mark	Total:	
☐	$	OUT OF NETWORK MAXIMUM REIMBURSEMENT CHARGE 250% of Medicare vs. 80% R&C

TOTAL REQUEST OF REIMBURSEMENT: $ $ 0.00

Reimbursements for the following parties:

	Names:
☐ *Self*	_____
☐ *Spouse*	_____
☐ *Child*	_____

YOUR SIGNATURE

By signing this form, I acknowledge that I am responsible to pay my Deductibles/Co payments/Out of Pocket Maximums under the CIGNA Open Access Plus Basic Plan. I understand this if I request reimbursement fraudulently, I will be responsible for pay Legal Services NYC back for the amount I was reimbursed.

Your Signature: _____ Date: _____