St. Johns County School District
Hospital Indemnity Plan

Request for Reimbursement Claim Form

Important Plan Reminder: Requests for reimbursement must be submitted within six (6) months from the date you are discharged from the hospital for your hospital indemnity claim to be reimbursed.

Participant Information			
Employer Name St. Johns County School District	**Group #** 463	**Today's Date**	**Daytime Phone Number**
Employee Name	**Employee ID#** or **Last 4 digits of SSN**		**Email Address**
Employee Mailing Address			

Summary of Hospital Indemnity Plan Benefits

Inpatient Hospital Admissions Plan Year: January 1st – December 31st of each year	**Inpatient Hospital Benefit**
Length of Stay 1st – 10th day 11th – 180th day	 Plan pays $200 per day. Plan pays $100 per day.

Steps to request a Hospital Indemnity Plan reimbursement:

Step 1. Complete this form and attach an itemized bill or Explanation of Benefits from your medical plan provider. Be sure it includes the dates you were hospitalized.

Step 2. You have several options for submitting your Hospital Indemnity reimbursement requests:

- **Fax** your request to **1(407)786-2999**.
- **Mail** your request to:

Preferred Benefit Administrators
PO Box 916188
Longwood, FL 32791-6188

Questions regarding your Hospital Indemnity Plan coverage or status of reimbursement should be directed to:

Preferred Benefit Administrators
Toll-free: (888) 524-2777
www.PreferredTPA.com