



St. Johns County School District Hospital Indemnity Plan



Request for Reimbursement Claim Form

Important Plan Reminder: Requests for reimbursement must be submitted within ninety (90) days 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: 1/1/2022-12/31/2022	Inpatient Hospital Benefit
Length of Stay 1 st – 10 th day 11 th – 180 th 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 **(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