BOST
WORKPLACE BENEFITS

FACSIMILE TRANSMITTAL SHEET

TO: DEPARTMENT OF

Claims | Policyholder Changes

FROM (POLICYHOLDER):

COMPANY:

BOST Benefits

DATE:

FAX NUMBER:

1.724.923.4712

TOTAL NO. OF PAGES INCLUDING COVER:

PHONE NUMBER:

1.724.657.3443 (choose option for claims)

1.877.283.7600 (choose option for claims)

GROUP NAME (EMPLOYER):

EMAIL:

Claims@BOSTbenefits.com

PolicyChanges@BOSTbenefits.com

POLICYHOLDER EMAIL:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ OTHER

Please find attached my claim form and documents for processing.