



FACSIMILE TRANSMITTAL SHEET

TO: DEPARTMENT OF

FROM (POLICYHOLDER):

Claims | Policyholder Changes

COMPANY:

DATE:

BOST Benefits

FAX NUMBER:

TOTAL NO. OF PAGES INCLUDING COVER:

1.724.923.4712

PHONE NUMBER:

GROUP NAME (EMPLOYER):

1.724.657.3443 (choose option for claims)

1.877.283.7600 (choose option for claims)

EMAIL:

POLICYHOLDER EMAIL:

Claims@BOSTbenefits.com

PolicyChanges@BOSTbenefits.com

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

Please find attached my claim form and documents for processing.

www.BOSTbenefits.com

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