

# Deductible Credit Form

Required proof of previous deductible met must be attached

Please remit to:

Benefit Solutions, Inc. (BSI)  
12121 Harbour Reach Dr., Suite 105  
Mukilteo, WA 98275  
ATTN: WAHIT Deductible Credit



Date	Member Prefix (PLEASE CIRCLE) <b>WAH / NWB / ZNG</b>	Member Identification (NUMERIC)
Company Name		
Employee Name (PLEASE PRINT)		

Your new plan will credit amounts applied to your calendar year deductible from your current employer's prior insurance plan for Medical and/or Dental. Applied deductible amounts must have been accrued within the same calendar year as the effective date of your coverage. This credit applies only to NEW groups (not individuals coming into an existing WAHIT plan). **Please note:** Deductible credit never includes 4th quarter carry-over from the prior year.

- A FULLY COMPLETED DEDUCTIBLE CREDIT FORM MUST BE RECEIVED BY BSI WITHIN 90 DAYS OF THE FIRST DAY OF YOUR EMPLOYER'S ORIGINAL EFFECTIVE DATE. FORMS RECEIVED AFTER 90 DAYS WILL BE DENIED DEDUCTIBLE CREDIT.**
- You must list the dollar amount met by each member of your family separately.**
- Appropriate documentation is required to process your deductible credit information.** Please attach, either a copy (front and back) of the most current Explanation of Benefits (EOB) or a report from your previous carrier that lists the following information: Prior Carrier Name, Member Name, Member Date of Birth, and Amount of medical and/or dental deductible satisfied for the current calendar year for each family member.  
**Please Note:**
  - Website print outs must include the calendar year in which the deductible was applied.
  - Do not highlight the deductible on the EOB form.
- You may only submit the Deductible Credit Form from each employee/family one time.** For this reason, we advise you to wait to submit your Deductible Credit Form until all claims from your previous carrier have been processed but within the 90 days (#1 above).

MEMBERS NAME (PRINT YOUR NAME AND THE NAME OF EACH COVERED FAMILY MEMBER)	DATE OF BIRTH	MEDICAL	DENTAL
		DEDUCTIBLE \$ CREDITED THIS YEAR	DEDUCTIBLE \$ CREDITED THIS YEAR
EMPLOYEE		\$	\$
SPOUSE		\$	\$
CHILD		\$	\$
CHILD		\$	\$
CHILD		\$	\$
CHILD		\$	\$

I certify that the expense information I have provided is true and complete. I have attached required deductible documentation for each member listed on this form.

EMPLOYEE SIGNATURE

PLEASE SEND THIS FULLY COMPLETED FORM TO THE ADDRESS LISTED ABOVE.

<b>INTERNAL USE ONLY</b>	MEMBER ID	WORK LOCATOR #
	GROUP NUMBER	EFFECTIVE DATE