



Major Medical Credit Deductible

DATE	MEDICAL DEDUCTIBLE IND. FAM. \$ \$	DENTAL DEDUCTIBLE IND. FAM. \$ \$	MEDICAL PLAN NUMBER: (OFFICE USE ONLY)
COMPANY NAME			
EMPLOYEE NAME			
EMPLOYEE SOCIAL SECURITY NUMBER			

Regence BlueShield will apply amounts **credited** toward your calendar year deductible on your prior group program toward your calendar year deductible on your new program.

Please list below the total amounts **credited** to your deductible for this year.

Please attach required proof, such as a copy of the Explanation of Benefits or a statement from your prior carrier.

MEMBER'S NAME <small>(list your name and the name of each family member)</small>	DATE OF BIRTH	MEDICAL	DENTAL
		DEDUCTIBLE CREDITED THIS YEAR: _____(year)	DEDUCTIBLE CREDITED THIS YEAR: _____(year)
EMPLOYEE		\$	\$
SPOUSE		\$	\$
CHILD		\$	\$
CHILD		\$	\$
CHILD		\$	\$
CHILD		\$	\$

I certify that the expense information I have provided is true and complete.

X _____
EMPLOYEE SIGNATURE