

**\*EXPLANATION OF UNREIMBURSED CLAIMS\***

03/19/2008

EMPLOYER: Sample Company

PARTICIPANT: Susan Sample

PLAN TYPE	TRANSACTION DATES FROM - THROUGH	CLAIM #	AMOUNT REQUESTED	AMOUNT ELIGIBLE	AMOUNT DENIED	REASON FOR DENIAL
MED	01/01/07 - 01/01/07	SMU070230006	\$250.00	\$0.00	250.00	AMOUNT WAS COVERED BY INSURANCE
DEP	02/01/07 - 02/28/07	SMU070230004	\$1,000.00	\$0.00	1,000.00	FUTURE SERVICE DATE

Payment of any reimbursable amount will be sent to you separately in accordance with your employer's usual processing schedule. If your claim was denied for missing/incorrect information, you may re-submit by providing the missing/correct information using this Explanation of Unreimbursed Claims instead of a reimbursement request form. All submissions must be received prior to the end of the run out date to be eligible.

You may appeal our decision by sending a written request to Crosby within 180 days of the date of this notice. The appeal request must include the following: Participant's and employer's name, participant's Social Security Number or employee ID number, date(s) of service, provider name, claim amounts, a copy of the Explanation of Unreimbursed Claims or the claim number, a description of the problem, steps previously attempted to reach resolution, and any additional documentation or explanation in support of your request.

The appeal should be sent to:  
 Claims Appeal Coordinator  
 Crosby Benefit Systems, Inc.  
 P. O. Box 929125  
 Needham, MA 02492-9125

Please refer to our Reimbursement Request Forms or our website for guidance on eligible expenses and claim filing instructions. If you have questions about this denial, please call 617-928-0700 / 800-462-2235 or email: [servicecenter@crosbybenefits.com](mailto:servicecenter@crosbybenefits.com).

Susan Sample  
 14 Main Street  
 Line 2  
 Boston, MA 02222

**CROSBY**  
*Benefits People*