



**REQUEST FOR PROFESSIONAL LIABILITY
RECEIPT FOR REIMBURSEMENT**

Please Print

MEMBER NAME: _____

CERTIFICATE # OR SS#: _____

MAILING ADDRESS: _____

WORK PHONE: _____

FAX # OR E-MAIL: _____

PERIOD REQUESTED

PLEASE NOTE: Receipts will only be prepared for periods already fully paid. In addition, we will provide only one receipt per 12 month period free of charge. Additional receipts will be prepared at a prepaid cost of \$5.00. Incomplete request forms will not be processed.

SPECIFY DATE RANGE

From Date: _____ Through Date: _____

Signature: _____ Date: _____

PLEASE ALLOW 3-5 DAYS FOR YOUR REQUEST TO BE PROCESSED

MAIL THE FULLY COMPLETED REQUEST FORM TO:

Mass Benefits Consultants, Inc.
PO Box 828
Annandale, VA 22003-0828

OR FAX TO: 703-642-2240