Premium Refund Request Form

This form should be used to request refunds of premium paid for September 1, 2017 or later coverage periods. Proof of claim forms will be provided at a later date to request premium refunds for coverage periods prior to September 2017.

Email the completed form along with supporting documents to confirm your group enrolled with another carrier effective September 1, 2017, to: enroll@evergreenmd.org

CONTACT INFORMATION

Company Name:
Group ID:
Company Address:
Phone Number:
Email Address:
Group's Broker or Administrator:
Name of Individual Completing Form:

PAYMENT INFORMATION

Premium Payment Amount:
Premium Payment Date:
Premium Payment Method: Check
Coverage Period For Which Payment Was Made: From: To:
Refund Requested:
Outstanding Balance Due To Evergreen (If Any): 0.00

COVERAGE INFORMATION

Date Group Informed Evergreen Of Termination:
How Did Group Inform Evergreen Of Termination:
Name Of Group's New Carrier:
Date Coverage Became Effective With New Carrier: