

# Childbirth Preparation Class Reimbursement Form

Please complete the following form and attach your payment receipt for reimbursement. You will receive reimbursement of up to \$50 per female member/per year. Mail this form with receipt to:

**ConnectiCare, Inc. and Affiliates**  
**Attention: Claims**  
**175 Scott Swamp Road**  
**Farmington, CT 06032-3124**

Member Name: \_\_\_\_\_

Member ID Number: \_\_\_\_\_ - \_\_\_\_\_

Date of First Class: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Instructor Name: \_\_\_\_\_

Services rendered in (circle one):

Hospital

Physician Office

Other

Total Charges: \$\_\_\_\_\_

**ConnectiCare, Inc. & Affiliates**