

Payment reminder for COBRA/Retiree/Part time benefits

Name: _____ Date: _____

I.D. #: _____ School District: _____

For month(s) of: _____ Amount: \$ _____

Please circle type of coverage: Dental / Vision / Medical

Check payable to: School Claims Service, LLC
Remittance Department
P.O. Box 812
New Cumberland, PA 17070-0812

If you do not wish to continue this coverage, please notify us immediately so our records can be adjusted accordingly. Please return this slip with your check.



P.O. Box 812 • New Cumberland, PA 17070-0812 • (866) 403-7700

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