

Request for Hardship Fund Payment
(for Individuals on Dartmouth College Medicare Supplemental Plan)

Name: _____

Address: _____

Phone: _____

Date of medical service or purchase:	Description of medical service or purchase:

Describe Circumstances: _____

Signature: _____

Date: _____

Attach copies of all incurred expenses or payment receipts to this completed form and deliver to: Ashley Buck, Health Benefits Administrator at the address above or HB 6042.