

# 2006 CLAIM FORM

1. Employee must complete this form in full.
2. Form is not complete unless the employee signs and dates below.



PO Box 2639 • Lilburn, GA 30048 • 770-451-7550

PART A — EMPLOYEE INFORMATION			
1. Employee's Name ( <i>first, MI, last</i> )	2. Sex O M O F	3. Date of Birth	4. ID Number
5. Home Address ( <i>street, city, state and zip code</i> )	6. Marital Status:   O Single   O Married   O Divorced   O Widowed		
	7. Employer's Name		
8. Are you covered by any other health insurance, student plan, prepaid medical plan, Medicare, Medicaid, etc? <input type="radio"/> Yes <input type="radio"/> No (if no, skip to Part B)			
9. Name of Other Health Plan		Phone Number	
Address of Other Health Plan ( <i>street, city, state and zip</i> )		Effective Date	

PART B — DEPENDENT INFORMATION <small>(if no dependents skip to Part C)</small>			
1. List all covered dependents on your policy and their relationship to the employee:			
Full Name	Relationship	Sex	Date of Birth
		O M O F	
		O M O F	
		O M O F	
		O M O F	
		O M O F	
<i>For all dependents over the age of 19, you must provide proof of their full-time student status each semester/quarter for any claims to be processed. Please provide a copy for the current semester/quarter when returning this claim form.</i>			
2. Are any dependents listed above covered by any other health insurance, student health plan, prepaid medical plan, Medicare, Medicaid, etc.? <input type="radio"/> Yes <input type="radio"/> No (if no, skip to #4.)			
3. List all dependents covered under other insurance below: ( <i>you may use the back of form if necessary</i> )			
Name Of Dependent	Name/Address/Phone Number of other Health Plan	Effective Date	
4. Are any dependents listed totally disabled? <input type="radio"/> Yes <input type="radio"/> No ( <i>if yes, list below</i> )			
Name of Disabled Dependent(s)			

PART C — AUTHORIZATION FROM EMPLOYEE TO RELEASE INFORMATION	
<p>I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, peer review organization, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, employer or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to the group policyholder, my employer, third party administrator, or its legal representative, any and all such information.</p> <p>I UNDERSTAND the information obtained by use of the Authorization will be used to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released to any person or organization EXCEPT to the group policyholder, my employer, third party administrator, reinsuring companies, the Medical Information Bureau, Inc., peer review organization, or other persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.</p> <p>I KNOW that I may request to receive a copy of this authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for two and one half years from the date shown below, or for the duration of this claim, if longer.</p> <p>NOTICE TO FLORIDA RESIDENTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree.</p>	
Employee's Signature	Date