STATEMENT OF CLAIM — MEDICAL

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

1 Employees must compete Parts A and B.
2. Ask patient's physician to complete reverse side of this form.
3. Attach bills for covered expenses to this form. Bills must show: patient's name, date, nature of illness, type of service ad amount charged. Drug bills must also show prescription (Rx) numbers.
4. Attach all itemized statements & bills to this form and mail to address on the back of your ID card. **PLEASE COMPLETE IN FULL.**

PART A — EMPLOYEE INFORMATION

1. Employee's Name *(first, MI, last)*	**2.** Sex O M O F	**3.** Date of Birth
Home Address *(street, city, state and zip code)*	**5.** Employer's Name	
	6. Marital Status: O Single O Married O Divorced O Widowed	

PART B — PATIENT INFORMATION & AUTHORIZATION TO RELEASE INFORMATION

7. Claim is for: O Self O Spouse O Unmarried Dependent Child
If "Self" skip to question 12

8. Patient's name | **9.** Sex O M O F | **10.** Date of Birth

11. *Employee, answer only for claim on unmarried dependent child:*

Is child, age 19 or older, fully dependent on you for principal support and a full-time student? O Yes O No   Is child employed? O Yes O No

If answer is yes to either of above, complete the following:

Employer or school name | Address *(street, city, state, zip code)*

Are natural parents divorced/separated? O Yes O No   Does natural parent w/o custody have financial responsibility for health expenses? O Yes O No

Is this dependent covered by any other health insurance, student health plan, prepaid medical plan, Medicare? Yes O No O

12. *Complete this question and either 13 or 14.*

Is this condition related to employment? O Yes O No   If "Yes", is claim being made for Worker's Compensation? O Yes O No

13. Is this claim due to an accident? O Yes O No   Nature of Injury?

How did it happen?   Where?   When?

14. Is this claim due to an illness? O Yes O No   Nature of illness?

When did symptoms begin?   When was a physician first consulted?

Name of physician: Address:

15. Did you or the patient receive, seek or will be seeking any monetary recovery from any person or entity who was responsible for causing such injury or sickness to you or the patient for claim being filed? O Yes O No

16. Did you or the patient receive a discount, credit or reduction on any of the expenses submitted? O Yes O No

17. Is, or was, this patient totally disabled? O Yes O No   *If "Yes", give dates:* From: To:

18. Is your spouse employed? O Yes O No   *If "Yes", complete question 19.*

19. Name of spouse	Name of Spouse's Employer
Date of Birth	Address
	Phone Number

20. Are you or your spouse covered by any other health insurance, prepaid health plan, Medicare or other government plan? O Yes O No
If "Yes", complete question 21.

21. Name of insured	Insurance Company or group plan's name
Certificate number	Address
Policy Number	Phone Number

22. AUTHORIZATION TO RELEASE INFORMATION

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.

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.

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.

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.

Employees Signature   Date   Spouse's Signature *(for dependent claims only)*   Date