

CLAIM INFORMATION

Group Number <input type="text"/>	Employee's Name <input type="text"/>	Employee's ID <input type="text"/>	Telephone Number <input type="text"/>
Employee's Street Address <input type="text"/>	City <input type="text"/>	State <input type="text"/>	Zip Code <input type="text"/>
Patient's Name <input type="text"/>	Patient's Date of Birth <input type="text"/>	Patient's Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other (specify) <input type="text"/>	
Patient's Occupation <input type="text"/>	If this is on a dependent over age 19, <input type="checkbox"/> Student (Give name & location of school) <input type="text"/> <input type="checkbox"/> Handicapped		

Is the patient covered by other group insurance? (including Champus or Medicare) YES NO

IF YES, Name of individual maintaining coverage Relationship to patient

Name & address of that insurance company

Policy Number

Nature of Illness or Injury

Date Illness or Injury began First date of treatment for Illness or Injury

IF INJURY, Where

How

Work related? Yes No IF YES, briefly explain:

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or medical condition and/or treatment of me and any other non-medical information of me to give to Benefit Plan Administrators Company or its legal representative, any or all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by Benefit Plan Administrators Company to determine eligibility for benefits under any existing policy. Any information will not be released by Benefit Plan Administrators Company to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my 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 the 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. I CERTIFY that the above information in support of my claim is true and correct.

Signature _____	Signature of Patient _____ (if age 18 or older)	Date Signed _____
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NOTE: ALL MEDICAL BILLS SHOULD INCLUDE THE FOLLOWING:

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|--------------------------------------------|-------------------------------------------------------|
| 1. Name of patient. | 4. The amount charged for each service. |
| 2. A complete description of each service. | 5. The diagnosis for each illness condition. |
| 3. The date of each service. | 6. Drug prescription number - and drug name if known. |

PLEASE SEND THE ORIGINAL BILLS . . . NOT PHOTOCOPIES.