



1733 Park Street, Suite 300
 Naperville, IL 60563-0565
 (630) 416-1111

MEDICAL CLAIM FORM

| | | |
|--|---------|---|
| PART 1: Complete for all claims | | |
| EMPLOYEE'S NAME (Last) | (First) | (Middle) |
| EMPLOYEE'S ADDRESS | | EMPLOYEE IDENTIFICATION NO. |
| EMPLOYEE'S ADDRESS | | AREA CODE & PHONE NUMBER |
| EMPLOYER | | POLICY NUMBER |
| ARE YOU <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED | | |
| DO YOU HAVE MORE THAN ONE EMPLOYER IF YES, GIVE NAME AND ADDRESS OF EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| THIS CLAIM IS FOR <input type="checkbox"/> MALE EMPLOYEE <input type="checkbox"/> FEMALE EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD | | PATIENT'S DATE OF BIRTH |
| GIVE NATURE OF ILLNESS OR INJURY | | IS PATIENT ELIGIBLE FOR MEDICARE BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | IF CLAIM IS DUE TO ACCIDENT, STATE WHEN, WHERE AND HOW IT OCCURRED |

PART 2: Complete if you are married or divorced

| | | |
|----------------------------------|------------------|---|
| NAME OF YOUR SPOUSE OR EX-SPOUSE | DATE OF BIRTH | IS YOUR SPOUSE/EX-SPOUSE EMPLOYED? IF YES, NAME OF THEIR EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO |
| NAME OF HEALTH BENEFIT CARRIER | IDENTIFICATION # | AREA CODE & PHONE NUMBER |
| | | <input type="checkbox"/> SINGLE COVERAGE <input type="checkbox"/> FAMILY COVERAGE |

PART 3: Complete if for a dependent other than your spouse

| | | | |
|--|---|--------------------------|--|
| NAME OF DEPENDENT | IF CHILD OVER 19, INDICATE: <input type="checkbox"/> HANDICAPPED <input type="checkbox"/> STUDENT (GIVE NAME & PHONE NUMBER OF SCHOOL) <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME | | |
| IS THIS DEPENDENT EMPLOYED? IF YES, NAME AND ADDRESS OF EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO | | EMPLOYER TELEPHONE | |
| NAME OF DEPENDENT'S GROUP HEALTH BENEFIT CARRIER | | | |
| IS THIS DEPENDENT COVERED BY ANY OTHER PERSON'S NOT LISTED ABOVE? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| NAME OF HEALTH BENEFIT CARRIER | ID NUMBER | AREA CODE & PHONE NUMBER | |
| NAME OF INSURED | RELATIONSHIP TO DEPENDENT | DATE OF BIRTH | |

PART 4: Complete for all claims

I hereby authorize any insurance company, prepayment organization, employer, hospital, physician, pharmacy, clinic or any other organization to release all information with respect to myself or any of my dependents which may have bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information in support of this claim is true and correct. A photostat of this authorization shall be as valid as the original.

DATE _____ SIGNATURE OF EMPLOYEE _____

DATE _____ If claim on spouse signature _____