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**CLAIM FORM**  
 THIS FORM MUST BE COMPLETED BY EMPLOYEE

<b>EMPLOYEE / EMPLOYER INFORMATION</b>		
EMPLOYER NAME _____		
EMPLOYEE NAME _____		I.D. NO: _____
DATE OF BIRTH _____		SEX _____
STREET ADDRESS _____		
CITY & STATE _____		ZIP _____
1. CLAIM IS BEING MADE FOR:		
<input type="checkbox"/> SELF <input type="checkbox"/> UNMARRIED CHILD TO AGE 19 <input type="checkbox"/> WIFE / HUSBAND <input type="checkbox"/> UNMARRIED FULL TIME STUDENT AGE 19 AND OVER ATTENDING _____		
2. PATIENT'S NAME _____		DATE OF BIRTH _____
		SEX _____
3. IS CLAIM DUE TO AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF "YES", WHERE DID ACCIDENT OCCUR? _____
DESCRIBE ACCIDENT _____		DATE OF ACCIDENT _____
4. IS THIS CLAIM THE RESULT OF A WORK RELATED ILLNESS OR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO      IF YES, PLEASE FILE WITH WORKER'S COMPENSATION CARRIER FIRST.		
5. IF MARRIED, IS YOUR WIFE/HUSBAND EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		5a. IF CLAIM IS FOR A DEPENDENT CHILD. IS THIS CHILD EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME _____		
EMPLOYER _____		EMPLOYER _____
ADDRESS _____		ADDRESS _____
6. IS PATIENT ALSO COVERED FOR ANY OTHER INSURANCE BENEFITS AS LISTED BELOW, EITHER AS AN EMPLOYEE OR DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, check box below which applies and complete 6a		6a. GIVE NAME AND ADDRESS OF OTHER COMPANY OR ORGANIZATION PROVIDING INSURANCE
<input type="checkbox"/> Group health insurance of any kind including Medicare		EMPLOYER _____
<input type="checkbox"/> Coverage of medical care expenses provided by an employer, a union welfare plan, any federal, state, provincial or other governmental program.		ADDRESS _____
<input type="checkbox"/> Other arrangements of benefits for individuals of a group (HSA)		OTHER INSURANCE IDENTIFICATION NO _____
<b>I authorize the release of any medical or other information necessary to process this claim.</b>		
7. EMPLOYEE'S SIGNATURE _____		SOC. SEC. NO. _____
		DATE _____
COMMENTS:   		