

## Employee Instructions

### How To Complete

1. Complete the Employee /Insured Statement below. Answer all the questions. Incomplete information causes delay in payment. Please sign "Release Of Information", Number 15.
2. Complete "Authorization To Pay Insurance Benefits", Number 16, if you wish to have payment made directly to the physician.
3. Complete Number 11 if spouse or dependent has other Group Health Coverages. Enter "None" if it does not apply.

Mail completed form to:



**Group Marketing  
Services, Inc.**

P.O. Box 19040 – Kalamazoo, Michigan 49019-0040  
(269) 343-2611

## Medical Benefits Form #733600

If these are additional bills for a claim already submitted, please put an "X" in this box

### To be completed by employee – (Please complete fully)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. Employee Name  |  | 2. Birthdate   |  | 3. Employee Social Security Number   |  | 4. Employer Name  |  |
| 5. Patient Name   |  | 6. Birthdate   |  | 7. Relationship<br>Self Spouse Child<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   |  | 8. Is Employee<br>Mar Sep Sng Div<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>    |  |
| 9A. Employee Address (Street, City, State, Zip Code)  |  | 9B. Patient Address If Different From Employee   |  |  |  | 10. Is Patient Full-Time College Student?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Where?<br>Graduation Date: |  |
| Telephone No.   |  | Telephone No.  |  |  |  |   |  |
| 11. Other Health Insurance (Including Medicare / Medicaid)<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Insurance Company Name, Address, Policy No.:                                      |  | 12A. Reason For Claim<br><input type="checkbox"/> Illness<br><input type="checkbox"/> Accident |  | 12B. Was Illness Or Accident Work<br>Related?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 12C. Auto Related<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, include<br>Auto Policy page                        |  |
| 13A. Describe Illness / Accident      Date:      Place:<br><br>How Did Accident Occur?  |  |  |  | 13B.<br>Is Patient Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Is Patient Released to work? <input type="checkbox"/> Yes <input type="checkbox"/> No                   |  |   |  |
| 14A. Has Patient Ever Had Same / Similar Symptoms or treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, please explain. Give Name / Address Of Physician Who First Treated Symptoms:   |  |  |  |  |  | 14B. Are Charges For?<br><input type="checkbox"/> Pre-Admission Testing<br><input type="checkbox"/> Second Opinion                          |  |
| 15. Patient's Or Authorized Person's Signature:<br>I Authorize The Release Of Any Medical And / Or Employer Information<br>Necessary To Process This Claim.<br><br>Signed By Patient, or Parent, if Minor      Date |  |  |  | 16. I Authorize Payment Of Medical Benefits To Physicians, Hospital, Or<br>Suppliers Of Medical Services And / Or Charges Attached To This Claim Form.<br><br>Employee Signature Only (Optional) |  |   |  |

Any person who knowingly signs an insurance claim containing any materially false, incomplete or misleading information is guilty of committing a fraudulent insurance act which is a crime and subject to criminal prosecution.