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: ☐ Self ☐ Spouse ☐ Child — Gender: ☐ M ☐ F

8. Is Employee: ☐ Mar ☐ Sep ☐ Sng ☐ Div

9A. Employee Address (Street, City, State, Zip Code)
Telephone No.

9B. Patient Address If Different From Employee
Telephone No.

10. Is Patient Full-Time College Student? ☐ Yes ☐ No
If Yes, Where?
Graduation Date:

11. Other Health Insurance (Including Medicare / Medicaid) ☐ Yes ☐ No
If Yes, Insurance Company Name, Address, Policy No.:

12A. Reason For Claim ☐ Illness ☐ Accident

12B. Was Illness Or Accident Work Related? ☐ Yes ☐ No

12C. Auto Related ☐ Yes ☐ No
If yes, include Auto Policy page

13A. Describe Illness / Accident Date: Place:
How Did Accident Occur?

13B.
Is Patient Disabled? ☐ Yes ☐ No
Is Patient Released to work? ☐ Yes ☐ No

14A. Has Patient Ever Had Same / Similar Symptoms or treatments? ☐ Yes ☐ No
If Yes, please explain. Give Name / Address Of Physician Who First Treated Symptoms:

14B. Are Charges For? ☐ Pre-Admission Testing ☐ Second Opinion

15. Patient's Or Authorized Person's Signature:
I Authorize The Release Of Any Medical And / Or Employer Information Necessary To Process This Claim.

Signed By Patient, or Parent, if Minor — Date

16. I Authorize Payment Of Medical Benefits To Physicians, Hospital, Or Suppliers Of Medical Services And / Or Charges Attached To This Claim Form.

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.