402 Graham Avenue • PO Box 1128 • Eau Claire, WI 54702-1128 • Phone: (800)236-7789 • (715)832-5535 • Fax: (715)838-8507

CLAIM INFORMATION

Group Number	Employee's Name	Employee's ID	Telephone Number
Employee's Street Address	City	State	Zip Code
Patient's Name	Patient's Date of Birth	Patient's Relationship to Employee ☐ Self ☐ Child ☐ Spouse ☐ Other (specify)	
Patient's Occupation	If this is on a dependent over age 19, ☐ Student (Give name & location of school) ☐ 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 physican, 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 ________________________

NOTE: ALL MEDICAL BILLS SHOULD INCLUDE THE FOLLOWING:

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

PLEASE SEND THE ORIGINAL BILLS . . . NOT PHOTOCOPIES.