

Accident/Hospital Indemnity Wellness Benefit Claim Form

Policy Number:

All Fields are required.

Policyholder Information:

Last Name Suffix First Name MI

Date of Birth (mm/dd/yy) Telephone Number where we can reach you

Home Address

City State Zip Code

Check box if this is permanent address change.

Patient Information:

Last Name First Name Date of Birth (mm/dd/yy)

Sex: Male Female
 Relationship: Primary Policyholder Spouse Dependent Child

Treatment and Physician Information

Treatment Date: M M D D Y Y Y Y
 Mammogram Date: M M D D Y Y Y Y
 Pap Smear Date: M M D D Y Y Y Y

- | | | |
|---|--|---|
| <input type="checkbox"/> Annual Physical | <input type="checkbox"/> Blood Screening | <input type="checkbox"/> Dental Exam |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Flexible Sigmoidoscopy |
| <input type="checkbox"/> PSA (blood test for prostate cancer) | <input type="checkbox"/> Eye Exam | |
| <input type="checkbox"/> Pap Smear | <input type="checkbox"/> Mammogram | |

Physician's Phone Number:

Physician's Name

Physician's Street Address

Physician's City State: Zip:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

The Provider listed above is authorized to validate the information I have provided.

POLICYHOLDER/PATIENT SIGNATURE

FAMILY RELATIONSHIP, IF NOT POLICYHOLDER

DATE