ALLIED
BENEFIT SYSTEMS, 'INC.

SEND ALL CLAIMS TO: Allied Benefit Systems, Inc.
P. 0. Box 909786-60690, Chicago, IL 60690
Phone: (312) 906-8050, Fax: (312) 906-8359, Non-IL Toll Free: (800) 288-2078

MEDICAL CLAIM FORM

INSTRUCTIONS: Complete the form below. Please see the reverse side for more detailed instructions.

Return the completed form to Allied Benefit Systems, Inc.

EMPLOYEE'S STATEMENT OF CLAIM FOR GROUP HEALTH BENEFITS

1. CLAIM IS BEING MADE FOR:
   - ☐ Employee
   - ☐ Spouse
   - ☐ Unmarried Child. If child is 19 or over, benefits continued as:
   - ☐ Full time student, attending ______ School
   - ☐ Other

2. PATIENTS NAME: ______ DATE OF BIRTH: ______ SEX: ______

3. IS THIS CLAIM DUE TO AN ACCIDENT? ☐ Yes ☐ No
   IF YES. WHERE DID ACCIDENT OCCUR? ______
   DATE OF ACCIDENT: / /
   DESCRIBE ACCIDENT: ______

4. IS THIS CLAIM AS A RESULT OF A WORK RELATED ILLNESS OR INJURY? ☐ Yes ☐ No

5. ARE YOU (EMPLOYEE) MARRIED? ☐ Yes ☐ No
   IF *YES". IS YOUR SPOUSE EMPLOYED? ☐ Yes ☐ No
   IF *YES', PLEASE PROVIDE:
   NAME OF SPOUSE ______
   EMPLOYER OF SPOUSE ______
   ADDRESS OF EMPLOYER ______

   IF CLAIM IS FOR A DEPENDENT CHILD, IS YOUR CHILD EMPLOYED? ☐ Yes ☐ No
   IF 'YES", PLEASE PROVIDE:
   NAME OF DEPENDENT ______
   EMPLOYER OF DEPENDENT ______
   ADDRESS OF EMPLOYER ______

6. IS THE PATIENT COVERED UNDER ANY OTHER PLAN PROVIDING HEALTH BENEFITS? ☐ Yes ☐ No
   IF -YES-, PROVIDE THE NAME AND ADDRESS OF THE COMPANY OR INSURANCE CARRIER PROVIDING BENEFITS:
   NAME OF COMPANY OF INSURANCE CARRIER ______ (Area) TELEPHONE NUMBER ______
   STREET NUMBER ______ CITY ______ STATE ______ ZIP ______

7. EMPLOYEES NAME (PLEASE PRINT) ______ SOCIAL SECURITY NUMBER ______ (Area) TELEPHONE NUMBER ______
   STREET NUMBER ______ CITY ______ STATE ______ ZIP ______

8. AUTHORIZATION TO RELEASE INFORMATION:
   I hereby certify that the foregoing statements are true and correct to the best of my knowledge. I also authorize any hospital, physician, or other persons who have attended me or examined me or any of my dependents, to disclose to Allied Benefit Systems, Inc. and/or my employer any and all information with respect to any illness or injury, medical history, consultation, diagnosis or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

   PATIENT'S SIGNATURE ______ DATE ______
   (if other than Employee, omit if patient is a minor.)

   EMPLOYEE'S SIGNATURE ______ DATE ______

9. ASSIGNMENT OF BENEFITS:
   I hereby authorize payment directly to the provider of medical services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the benefit plan.

   EMPLOYEE'S SIGNATURE ______ DATE ______

10. NAME OF EMPLOYER ______ GROUP NO. ______ (Area) TELEPHONE NUMBER ______
    STREET NUMBER ______ CITY ______ STATE ______ ZIP ______

INSTRUCTIONS FOR FILING A CLAIM

COMPLETE EMPLOYEE'S STATEMENT: PLEASE BE SURE TO ANSWER EVERY QUESTION.

All bills must show patient's name, date(s) of treatment, nature of treatment (diagnosis) and fee for each service.

If a claim is for prescription drugs, attach bills to form after completing "Employee's Statement of Claim" section. All bills must show: patient's name; prescription number; date(s) of purchase; and charge.

If claim is for registered nurses, x-ray, laboratory or medical equipment, attach bills to the form after completing "Employee's Statement of Claim" section. All bills must show: patient's name; nature and date(s) of service; amount of charge; and prescribing physician. Additional data will be requested if needed.

This list follows the numerical order on the claim form:

1. Check the appropriate box for whom the claim is being made.

2. Provide the patient's name, date of birth, and sex.

3. Check the appropriate box (yes or no) if the claim is due to an accident. State where the accident occurred and the date of the accident. Please provide a brief description of the accident.

4. Check the appropriate box (yes or no) if the claim is work related.

5. Check the appropriate box(es) if the employee is married and if the spouse is employed. Provide the employer's name and address.

5a. If the claim is for a dependent child, check the appropriate box if the child is employed. Provide the employer's name and address.

6. If the patient is eligible for benefits under another plan, please check the appropriate box and provide the name and address of the insurance carrier or company providing the other benefits for the patient.

7. Provide the employee's name and address.

8. Sign and date the claim form.

9. Sign and date the Assignment of Benefits, if applicable.

10., Provide the employer's name and address.

11. Mail the claim form and the itemized bill to **Allied Benefit Systems, Inc. P.O. Box 909786-60690, Chicago, 11 60690.** KEEP A COPY FOR YOUR RECORDS.

IMPORTANT ITEMS TO NOTE

1. All charges must be submitted within the time frame specified in the summary plan description. Failure to do so will result in the denial of the charges.

2. From time to time, additional information may be requested in order to process a claim. Any additional information, i.e., other insurance payments, completed claim forms, subrogation forms, accident details, police reports, etc., must be submitted when requested. Failure to do so may result in the denial of the claim.

3. ALWAYS retain a copy for your records.