

GROUP HEALTH CLAIM FORM

To Be Completed by the Employee

Grp Number: _____		Name of Employer: _____	
Employee Name: _____		EE ID #: _____	Date of Birth: _____
Claimant Name: _____		Relationship to Employee: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child	
Is the claimant employed? <input type="radio"/> Yes <input type="radio"/> No		Is child a full-time student? <input type="radio"/> Yes <input type="radio"/> No	
Is this claim a result of: <input type="radio"/> Illness <input type="radio"/> Accident			

Please complete the following information for Injury

Date of Accident: _____	Where did the injury occur: _____
How did the injury happen: _____	
Is any other insurance involved? <input type="radio"/> Yes <input type="radio"/> No	
If YES, please provide the Name, Address & Policy # of the other carrier: _____	

Is this claim in any way occupational in nature? Yes No
Is this claim covered by Workman's Compensation? Yes No

Do any family members have coverage under any other insurance plan? Yes No

I declare that the above information is true and correct and is the basis under which benefits are provided under this Plan. I authorize the release of any information that may be necessary in determining benefits payable under this plan. I have read and agree to abide by the Subrogation and Reimbursement provisions of this Plan contained in the Summary Plan Description.

_____ Signature of Claimant	_____ Date
_____ Signature of Employee	_____ Date

I authorize payment of benefits to the physician or supplier of service:

Signature of Employee

SUBMIT COMPLETED FORM TO:
CORE Benefits, Inc.
P.O. Box 80465
Fort Wayne, IN 46898-0465
Ph: 260.492.7451 866.744.8482 Fax: 260.492.7292