

# CLAIM FORM

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Commerce Benefits Group

www.CommerceBenefitsGroup.com

## MEDICAL

PLEASE PRINT OR TYPE			
1. EMPLOYEE'S NAME (Last) (First)		AGE	SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
EMPLOYEE'S ADDRESS: (No. Street, City, State, Zip Code)		HOME PHONE NUMBER: ( )	
2. POLICY NUMBER:	SS#:	DATE INSURED:	OCCUPATION
3. ARE YOU MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF SPOUSE & NAME, ADDRESS & TELEPHONE NO. OF SPOUSE'S EMPLOYER	
4. IF CLAIM IS MADE ON BEHALF OF ONE OF YOUR DEPENDENTS, ANSWER THESE QUESTIONS IN ADDITION TO ALL OTHER QUESTIONS.			
NAME OF PATIENT & ADDRESS:		DATE OF BIRTH	MARRIED <input type="checkbox"/> YES <input type="checkbox"/> NO RELATIONSHIP TO INSURED
IF OTHER THAN SPOUSE, NAME & ADDRESS OF EMPLOYER, IF ANY		IF NOT EMPLOYED, HOW LONG HAS DEPENDENT BEEN SUPPORTED ENTIRELY BY YOU?	
5. DATE SICKNESS BEGAN OR INJURY OCCURRED			
6. STATE FULLY NATURE OF SICKNESS OR INJURY			
7. IF INJURED, STATE FULLY HOW AND WHERE INJURY OCCURRED			DID INJURY OCCUR WHILE ON DUTY? <input type="checkbox"/> YES <input type="checkbox"/> NO
8. HAS CLAIM BEEN FILED OR WILL CLAIM BE FILED UNDER ANY WORKER'S COMPENSATION ACT OR SIMILAR LAW?			<input type="checkbox"/> YES <input type="checkbox"/> NO
9. ARE ANY OF THE EXPENSES FOR WHICH CLAIM IS BEING MADE COVERED BY: (INCLUDE ANY PLAN OR INSURANCE CARRIED BY DEPENDENT)			
(A) Any other group insurance or any medical plan because of membership in group? .....			<input type="checkbox"/> YES <input type="checkbox"/> NO
(B) Any group or prepayment plan? .....			<input type="checkbox"/> YES <input type="checkbox"/> NO
(C) Any federal, state or other governmental plan? .....			<input type="checkbox"/> YES <input type="checkbox"/> NO
(D) Any medical plan sponsored by a school or college? .....			<input type="checkbox"/> YES <input type="checkbox"/> NO
If the answer to any of the above (91 - 9D) is "yes", complete (A) and (B) below:			
A. Name and address of employer if a plan through an employer:			
B. Name, address of the other insurance company, contract or policy number:			
Authorization The above information is correct to the best of my knowledge and I hereby authorize any hospital, physician or pharmacist to furnish the Claims Administrator any information desired.			
Date: _____		Employee Signature: _____	
Name of Policyholder (i.e. Employer, Union or Association)			
AUTHORIZATION TO PAY: I hereby authorize payment directly to the healthcare provider, otherwise payable to me for the services as described below but not to exceed the reasonable and customary charge for those services.		SIGNED (Insured Person)	
➔		DATE:	
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the healthcare provider to release any information acquired in the course of my examination or treatment to: _____		SIGNED (Patient or parent if minor)	
➔		DATE:	

