



GROUP CLAIM FORM

See Instructions, Certification, and Authorization on back.
Certification and Authorization must be signed and dated.

Special Insurance Services, Inc.
P.O. Box 250349
Plano, Texas 75025-0349

INSTRUCTIONS FOR COMPLETING THIS FORM

- PART I** must be completed for all claims. If the patient is a dependent, we must have the information requested regarding other medical coverage (coverage provided by spouse's employer, Medicare, Champus, Workers' Compensation, Automobile, etc.)
- PART II** must be completed (by the employee) if the employee's full time hire date was less than 12 months prior to the dates of service for the claim. Both questions must be answered. If there is prior coverage, the prior carrier must provide a letter or certificate as proof of the coverage. Submission of prior coverage information to us may reduce or eliminate the Pre-Existing Condition limitation.
- Complete **PART III** if the patient was injured in an accident. Answer all questions completely. Attach a separate sheet with your answers to questions 3 & 4, if need. If the claim involves an automobile accident, attach a copy of the police report, if one was issued.
- The **employee's** signature is **required** in the Employee Certification section. The signature must be dated.
- The Medical Information Authorization must be signed by the **patient**, unless the patient is a minor or is incapacitated. This signature must be dated and is **required** for all claims.
- If you have any **itemized** bills relating to this claim, attach them also.
- If you have any questions regarding this form, please call our Customer Service Department at (972) 788-0699 or (800) 767-6811. Our FAX number is (972) 960-0377.
- When the form is completed, attach all required extra pages, and mail to:

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Plano, Texas 75025-0349

PART I To be completed by the Employee

EMPLOYEE INFORMATION:

- Name _____ Social Security # _____
Address _____ Daytime Telephone () _____
Date of Birth _____ Occupation _____ Full Time Hire Date _____
- Employer's Name _____ Address _____
- Your status at work: Full Time Part Time Disabled Terminated Leave of Absence
If you are not currently working, what was the last date you worked? _____

PATIENT INFORMATION:

- Name _____ Relationship to the Employee _____
- Is any other medical coverage available for this patient? Yes No
If yes: Name of Company providing coverage _____
Address _____ Telephone () _____
Insured/Member Name _____ Group Number _____

If the patient is a dependent and is age 19 or older, please attach current verification of full-time student status.

PART II To be completed by the Employee if hire date was less than 12 months ago

- Did you or any of your dependents have medical coverage prior to your date of hire? Yes No
If yes, please attach a certificate or letter from your previous carrier showing the dates of coverage and persons covered.
- Was the patient seen by a doctor during the six month period prior to the employee's hire date? Yes No
If yes, please give the name, address, and telephone number of all physicians seen during that period of time. Attach a separate sheet if needed.

PART III To be completed if claim involves an accident

- Date of Accident _____
- Work-related? Yes No
- Description of the injury _____
- How and Where did the accident occur? _____
- Automobile accident? Yes No If yes, attach the police report if one was issued.
- Is the patient covered by other insurance (Automobile, Workers' Compensation, Other Liability, etc.) because of this accident? Yes No
If yes, Name of Company _____ Telephone () _____
Address of Company _____
Insured's Name _____ Policy # _____

EMPLOYEE CERTIFICATION

Employee's signature and date required

I certify that all information given on this **GROUP CLAIM FORM** is complete and accurate.

Employee's Signature _____ Date _____

NOTE TO ALL PARTIES COMPLETING THIS FORM: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION****Signature is required**

I hereby authorize any physician, hospital, pharmacy, insurance company, Worker's Compensation carrier, Social Security office, Veterans Administration, retirement system, or other organization to release any information regarding the medical or mental health history, treatment, disability or benefits payable for this claim to Special Insurance Services, an authorized the Plan Sponsor. A photocopy of this authorization shall be as valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand that this authorization may be revoked at any time by providing written notice to Special Insurance Services, **except to the extent Special Insurance Services has taken action in reliance of this authorization, or to the extent that law allows Special Insurance Services to contest claims or coverage. Written notice must refer to Special Insurance Services and the authorization by indicating the date it was signed, and should be mailed to: Special Insurance Services, P.O. Box 250349, Plano, Texas 75025-0349.** By signing below I certify the above information as true and CORRECT to the best of my knowledge.

Special Insurance Services may use this information to determine what, if any, benefit can be provided for any coverage for which I may be eligible.

By State Law, you must be advised that: THE INFORMATION YOU AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, THE HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME ("AIDS").

The information you authorize for release may include your history of treatment for physical and/or emotional illness to include psychological testing and treatment records of alcohol and drug abuse.

Special Insurance Services may not condition treatment, payment, enrollment or eligibility on your completion of this authorization, except for purposes of making eligibility, underwriting or risk determinations.

Special Insurance Services agrees to maintain the confidentiality of all the Insured's nonpublic financial or medical information given to us by any authorized entities listed above; **however, federal law (HIPAA) requires you be advised information used or disclosed pursuant to this authorization may be subject to re-disclosure and is no longer protected by HIPAA rules.**

Name of Patient/Claimant		Signature of Patient/Claimant		Date Signed
Social Security Number	Address		City, State and Zip Code	

If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.**RETAIN A COPY FOR YOUR PERSONAL RECORDS**

Send to:

Special Insurance Services, Inc.

P.O. Box 250349

Plano, Texas 75025-0349

Phone: (972) 788-0699 or (800) 767-6811

Fax: (972) 960-0377

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