

CENTRAL UNITED LIFE INSURANCE INVESTORS CONSOLIDATED INSURANCE

MEDICAL EXPENSE CLAIM FORM

HELP SPEED YOUR CLAIM By Following These Easy Steps

1. You complete the "insured's Statement" portion of the claim form. (Please answer all questions and sign it.)
2. Have your physician complete a health Insurance Claim Form. Only your primary physician needs to complete a claim form. There is no need for a claim form from the Anesthesiologist, Radiologist, etc.
3. When you and your physician have completed the claim forms, return them to the address shown at the upper right along with any other itemized bills such as HOSPITAL and DRUG BILLS and a copy of the explanation of benefits from your primary insurance carrier.

NOTE: Please sign the "Authorization to Release information" on a Health Insurance Claim Form. This will avoid delay in handling your claim.

In addition, if you want benefits paid directly to the doctor, sign the "Authorization to Pay Benefits to Physician" on a Health Insurance Claim Form.

Please Remember To: ...

- Submit a new claim for each separate illness or injury.

Submit separate claim forms and bills for yourself and each of your dependents who have claims.

Please Do Not ...

- Do not send in cancelled checks or cash register receipts. These cannot be accepted
- Do not submit a list of expenses prepared by yourself. The actual bills are needed.
- Do not accumulate numerous bills for submission at the end of the year. Submit your bills periodically, especially if medical treatment covers a long period of time.

Return the following documents to us at the address below:

- This completed, signed claim form;
- Itemized bills;
- Documents showing the actual charges paid by you or on your behalf (such as Explanation of Benefit payment from your primary insurance carrier or Statement of Account from your health care provider).

Claims Department
P.O. Box 925309
Houston, Texas 77292-5309

Any person who, with intent to injure, deceive, or defraud, or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive may be guilty of a crime.

BILLS FOR PRESCRIPTION DRUGS AND MEDICINES

If your physician prescribes drugs or medicines which you buy at a drugstore, obtain a bill.

Make sure the bill shows:

- Your name
- Your dependent's name. If the drugs were prescribed for one of your dependents
- Prescription number
- Purchase data and amount of charge.
- Name of Physician prescribing the drugs or medicines.

Drugs and medicines which can be purchased without a physician's prescription are not covered under your policy.

INSURED'S STATEMENT	1.	INSURED'S NAME	POLICY NUMBER	SOCIAL SECURITY OR CERTIFICATE NUMBER
	2.	INSURED'S ADDRESS	CITY	STATE ZIP CODE
	3.	THIS CLAIM IS FOR: PLEASE GIVE NAME:		DATE OF BIRTH: 20
		INSURED <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEP-CHILD <input type="checkbox"/>		
		ARE YOU? IF CLAIM IS CHILD OVER 18 YEARS, IS THE CHILD A FULL TIME STUDENT?		
		SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NAME OF SCHOOL		
	4.	EVERY Question MUST BE Answered. (If your policy does not have a coordination of benefits clause, please skip to question #6)		
		A.	Does your spouse work? If yes, spouse's date of birth. / /	Yes <input type="checkbox"/> No <input type="checkbox"/>
		B.	If claim is on a child, does that child work full time?	Yes <input type="checkbox"/> No <input type="checkbox"/>
		C.	Is any other Hospital Plan or HMO offered to you through a job, union, association, etc?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	D.	Is any other Hospital Plan or HMO offered to your spouse or child where they work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	E.	Are you, your spouse or any of your eligible children covered under any other Plan or HMO?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	F.	If claim is on a step-child, is that child insured under natural parent's Plan or HMO?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	G.	If you answered "yes" to any of the above questions, 4-A through F, please complete the following:		
		NAME OF INSURED PERSON OR CHILD (You, Working Spouse or Child)	NAME OF EMPLOYER PRESENT OR RECENT	ADDRESS OF EMPLOYER
		_____	_____	_____
	H.	The name of the other insurance company _____		
		The address where claims paid: _____		
		The name of the other Group _____		
		Policy Number: _____		Certificate or Contract Number: _____
	5.	A. Do you have Medicare Insurance? (Part A - <input type="checkbox"/> YES <input type="checkbox"/> NO) (Part B - <input type="checkbox"/> YES <input type="checkbox"/> NO) Effective Date _____		B. Does your spouse or any of your children have Medicare Insurance? (Part A - <input type="checkbox"/> YES <input type="checkbox"/> NO) (Part B - <input type="checkbox"/> YES <input type="checkbox"/> NO) Name () Effective Date _____
	6.	If this is because of an accidental injury, please answer the following:		
		A. Where did the accident happen?		B. How did the accident happen?
		C. When did the accident happen? Date _____ Time _____ A.M. _____ P.M.	D. did the accident happen during the course of any employment for compensation or profit? <input type="checkbox"/> YES <input type="checkbox"/> NO	E. Was a Vehicle involved? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, the name of your No Fault Insurance Company _____
	7.	When was a doctor first seen for this sickness or injury? Date _____, 20____. Doctor's name? _____		

The above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, druggist, insurance company, employer, labor union, or association to release information to Central United/Investors Consolidated as is required to properly pay all benefits if any due me, my spouse, or child for this claim. This authorization is valid for 24 months. Revocation of the authorization must be submitted in writing. I or my representative is entitled to a copy of this authorization.

Date _____, 20____

SIGNATURE _____

INSURED

PATIENT (or if a Minor, Parent)

