



Group Accident Claim Form Outpatient Physician Expense Benefit

Please complete this form in full. If you have any questions, please contact our Claims Department. Claims can be mailed, faxed or emailed to the address, fax or email listed below.

CERTIFICATE HOLDER INFORMATION

Full Name of Policy Holder		Date of Birth	
Certificate Number	Social Security Number		
Phone Number	Email Address		
Street Address	City	State	Zip

CLAIMANT INFORMATION (If different)

Full Name of Claimant		Date of Birth	
Relationship of Claimant to Certificate Holder		Social Security Number	

OUTPATIENT PHYSICIAN EXPENSE BENEFITS DETAILS - Please provide the requested information below or an EOB, with date of service and reason for visit.

Name of Physician		Physician Phone Number	
Street Address	City	State	Zip
Date of Visit	Reason for Visit		

I represent that all statements and answers in this claim form are complete, true and correctly recorded to the best of my knowledge and belief and that I have appropriate knowledge to answer the questions for my spouse and children.

Signed at (city) _____ State _____ this _____ Day of _____ 20_____

Signature of Claimant _____

Owner (if other than Claimant) _____