CLAIM FORM
GROUP POLICY
8200001846

❑ CHECK HERE IF NEW ADDRESS SINCE LAST SUBMISSION. DATE RELOCATED ___/___/___

FORWARD COMPLETED CLAIM FORM TO: RURAL CARRIER BENEFIT PLAN
P.O. BOX 7404
LONDON, KY 40742

Phone: (800) 638-8432

PLEASE PRINT **TO BE COMPLETED BY INSURED MEMBER** **PLEASE PRINT**
All items must be answered in full before your claim can be processed.

Member's full name _____ Sex _____ Date of Birth _____

Member's mailing address _____
(Number and Street) (City) (State) (Zip Code)

Member's Subscriber ID _____ Enrollment Code SELF ONLY 381 SELF & FAMILY 382
(please circle one)

If claim is for a dependent, given name _____ Relationship _____ Date of Birth _____

Dependent's marital status: (check one) ❑ single ❑ married

Describe Sickness/Accident Suffered _____

If Accident: (a) Date of accident _____
(Month) (Day) (Year) (Hour)

(b) How and where did accident occur? _____

Was accident or sickness work related? ❑ Yes ❑ No If "Yes" please contact your workers' compensation office for guidance.

Physician's Name _____ Address _____

OTHER INSURANCE/MEDICARE COVERAGE INFORMATION

(See section on coordination of benefits in your Brochure)

IMPORTANT: This question must be answered and the form signed before claim can be processed.

(a) Are you or any member of your family covered under any health plan other than Rural Carrier Benefit Plan? ❑ Yes ❑ No

(b) If answer is "Yes" complete the following:

Person in whose name the other plan is issued: _____

Name of all dependents covered under the other plan _____

Name of Insurance Company or Plan _____ Effective Date _____

Address of Claims Office _____

Is this insurance through active employment? _____ Employment Effective Date _____

Policy or Contract Number _____ Is Plan Family _____ or Self only _____ coverage? (Check appropriate block)

(c) Is this other plan issued under a Group _____ or individual _____ contract? (Check appropriate block)

IMPORTANT: This question must be fully answered by persons age 65 or older and persons under age 65 receiving disability benefits through Social Security.

Medicare coverage (see your official Brochure) (a) Are you or any member of your family covered under Medicare? ❑ Yes ❑ No
(b) If "Yes" indicate name of person and check the type of coverage.

SELF: _____ ❑ Hospital (Part A) Effective Date _____ ❑ Medicare (Part B) Effective Date _____

SPOUSE: _____ ❑ Hospital (Part A) Effective Date _____ ❑ Medicare (Part B) Effective Date _____

DEPENDENT: _____ ❑ Hospital (Part A) Effective Date _____ ❑ Medicare (Part B) Effective Date _____

(c) If you or your spouse are 65 or over, indicate whether you are actively employed.

Self: ❑ Yes ❑ No Employer _____

Spouse: ❑ Yes ❑ No Employer _____

Authorization for direct payment of benefits.	I authorize payment directly to _____ (Print name of physician) for the Medical and/or Surgical Benefits otherwise payable to me. Date _____ , 20_____ Signed _____ (Signature of member)

I certify the information on this form is complete and accurate.

_____ _____
Signature of patient or member Date

WARNING: Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000, or imprisonment of not more than five years, or both. (18 U.S.C. 1001)

HAVE YOU ANSWERED EVERY QUESTION? _____ **HAVE YOU DATED AND SIGNED THIS FORM?** _____

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