



P.O. Box 6927
Columbia, SC 29260
Telephone: 803-462-0151 / 1-800-768-4375
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CLAIM FORM FOR GROUP MEDICAL BENEFITS / SHORT TERM DISABILITY

FOR OFFICE USE ONLY

NEW CLAIM CONTINUING CLAIM

Claimant should complete the entire form and sign. Be sure all questions are answered. If the question does not apply to your claim, mark "NA."

For all expenses claimed, you must attach itemized statements to include date, type, place of service, charge, and signature of the provider or representative.

Empty rectangular box for office use only.

EMPLOYEE NAME EMPLOYER GROUP # (see your ID card)

ADDRESS SOC.SEC.#

MALE FEMALE MARRIED SINGLE DIVORCED DATE OF BIRTH

ACTIVE RETIRED LAST DATE WORKED CLAIM ON SELF DEPENDENT (please check one)

PATIENT NAME RELATIONSHIP DATE OF BIRTH

IF FULL-TIME STUDENT, LIST NAME OF SCHOOL ANNUAL SALARY

HAS THIS CONDITION BEEN TREATED IN THE PAST? YES NO DATE FIRST SEEN

DATE LAST SEEN DOCTOR'S NAME & ADDRESS

CONDITION ILLNESS INJURY (please check one)

IF INJURY, DESCRIBE HOW ACCIDENT OCCURRED:

AT WORK HOME AUTO OTHER DATE

IF AUTO ACCIDENT, ATTACH TRAFFIC REPORT AND LIST BELOW THE NAME OF THE PARTY RESPONSIBLE FOR THE ACCIDENT AND THE AUTO INSURANCE CARRIER'S NAME AND ADDRESS

IF THIS IS A SHORT TERM DISABILITY CLAIM, HAVE YOUR EMPLOYER COMPLETE AND SIGN THIS STATEMENT.

LAST DATE WORKED FULL-TIME DATE RETURN TO WORK FULL-TIME

SIGNED POSITION/DATE

HAVE YOUR PHYSICIAN SIGN THIS STATEMENT:

I CERTIFY THE ABOVE CLAIMANT WAS TOTALLY DISABLED FROM TO AND WAS ABLE TO RETURN TO WORK FULL-TIME ON CONDITIONS/DIAGNOSIS

SIGNED DATE

ARE YOU OR YOUR DEPENDENTS ELIGIBLE FOR OTHER BENEFITS UNDER GROUP INSURANCE, MEDICARE, OR ANY OTHER PLAN OF COVERAGE? YES NO IF YES, LIST POLICY INFORMATION BELOW.

NAME AND ADDRESS OF INSURANCE COMPANY

POLICY NUMBER

I HEREBY CERTIFY THAT THE FOREGOING STATEMENTS, INCLUDING ANY ACCOMPANYING STATEMENTS, ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR ORGANIZATION TO RELEASE ANY INFORMATION TO PLANNED ADMINISTRATORS, INC. A COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

SIGNED DATE