

KLAIS & COMPANY, INC.

EMPLOYEE BENEFIT CONSULTANTS AND ADMINISTRATORS

1867 WEST MARKET STREET

AKRON, OHIO 44313-6977

(330) 867-8443

BENEFIT REQUEST FORM FOR GROUP MEDICAL BENEFITS

TO BE COMPLETED BY EMPLOYEE

1. Employer _____ City _____ State _____ Group # _____

2. Employee Name _____ Date of Birth ____/____/____

3. Home Address _____
Number _____ Street _____ City _____ State _____ Zip _____

4. Marital Status: Single Married Divorced Widowed Social Security Number _____ - _____ - _____

5. Telephone No. (____) _____

6. Is this claim for a dependent? Yes No If yes, give name _____
Relationship _____ Date of Birth ____/____/____ Married Yes No Full-time Student Yes No
Name & Address of University _____

7. Are you: Active Employee
 Retired: Date Retired _____
 Cobra Participant

8. Is this request based on an accident? Yes No If yes, give date _____
Where did the accident occur? _____
How did it happen? _____

9. Is this claim a result of a work related illness injury? Yes No

10. Is your spouse employed? Yes No If yes, give name of spouse _____ Date of Birth ____/____/____
Name of spouse's Employer _____ Phone No. (____) _____
Employer's Address _____

11. Is patient covered for benefits by any other: YES NO
A. Group Health Benefits of any kind thru an Employer, Union, Welfare Plan or a School?
B. Coverage of medical care expenses provided thru any Federal, State, Provincial or other Governmental Agency?
If any of the above are answered yes, please complete the following:
Other Employer _____ Other Insurance Co. or Benefits Plan _____
Address _____ Address _____
Telephone No. (____) _____ Telephone No. (____) _____ Policy No. _____
If Blue Cross show Group and Cert. No. from Blue Cross ID Card _____
Group No. _____ Cert. No. _____

12. To be completed regardless of age of patient
Is the patient covered under MEDICARE Hospital Insurance (Part A) Yes Eff. Mo. ____/ Day ____/ Yr. ____ No
Is the patient covered under MEDICARE Hospital Insurance (Part B) Yes Eff. Mo. ____/ Day ____/ Yr. ____ No

13. Is this patient related to the provider? Yes No If yes, describe the relationship _____

14. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacist to release any information requested with respect to this claim.
It is unlawful to knowingly provide false, incomplete or misleading facts or information regarding a claim for the purpose of defrauding or attempting to defraud to receive benefits. Penalties may include imprisonment, fines, denial of benefits, and/or civil damages.

Date _____ 20____ Signature of Employee _____
Date _____ 20____ Signature of Claimant _____

COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER (S)

Authorization to Pay Benefits: I hereby authorize payment directly to: any physician or provider of service for which I am submitting attached billings and charges.

For the expenses provided under my Group Medical Expense Benefits, I understand I am financially responsible for charges not covered by this authorization.

Signature _____