

IMPORTANT - READ CAREFULLY

SUBMIT COMPLETED FORM AND BILLS PROMPTLY TO:

- 1. Fill out Employee section.
- 2. Answer all questions to assure prompt service of your claim.
- 3. Attach all itemized bills not previously submitted.
- 4. **Sign the form.**

naa

North America
Administrators

P.O. BOX 1984
NASHVILLE, TN 37202

NOTE: THIS FORM MAY BE RETURNED IF NOT SIGNED!

MEDICAL CLAIM FORM

TO BE COMPLETED BY EMPLOYEE

**ANSWER ALL QUESTIONS THAT APPLY.
SIGN WHERE INDICATED BY **

Employee's Full Name		Employee Marital Status	M.	Div. Legal Sep.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Soc. Sec. Number
			S.				
			Wid.				
Home Address <small>(Number and Street)</small>		<small>(City)</small>	<small>(State)</small>	<small>(Zip Code)</small>	Telephone Number		
Employed by				Occupation		Date Employed	
Name of Group							

Claim is made for <input type="checkbox"/> Self <input type="checkbox"/> Dependent	Dependent's Name	Dependent's Marital Status	M.	Div. Legal Sep.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Relationship to Insured
			S.				
			Wid.				

Describe Disability

IF CLAIMANT WAS INJURED	Time: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Was claimant at work when the accident occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Employer
	Date accident occurred	Describe accident. (Tell how, when and where it occurred.)	
Was illness caused by work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has there been or will there be a claim filed for injury or illness with the workman's compensation carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Name of your spouse	Spouse's Birthdate	Spouse's Soc. Sec. #	Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Name, address and phone number of your spouse's employer
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Does your spouse have any insurance at his/her place of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," give name and address of the insurance company.
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Please provide names of all family members who are covered under this insurance and provide a copy of the insurance card:

Are you or any of your dependents covered under any other insurance plan other than as shown above or under any federal, state or other governmental program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," give name and address of the insurance company and provide a copy of the insurance card.
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Please provide names of all family members who are covered under this insurance:

Are you or your spouse covered under Medicare? SELF: <input type="checkbox"/> Yes <input type="checkbox"/> No SPOUSE: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide a copy of the Medicare card.	Do you or your spouse have more than one employer? If "Yes," give names and addresses of all employers.
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I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish North America Administrators, L.P. with full information regarding treatment rendered (including copies of their records). I/We also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish North America Administrators, L.P. with information regarding benefits to which I/We may be entitled. **(If claim for spouse, spouse also must sign.)** A copy or photocopy of this authorization shall be considered as effective and valid as the original.

Date	Employee's Signature 	Spouse's Signature 
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PLEASE BE SURE ALL BILLS NOT PREVIOUSLY SUBMITTED ARE FORWARDED WITH THIS CLAIM FORM.