

Limited Benefit Claim Form

MAIL PROCESSING CENTER, PO Box 29186 Shawnee Mission, KS 66201-9186 844-630-7500

		CLAIMANT INFORMATION				
Plan or Identification Number:	2. Name	2. Name of patient:			4. Patient's Date of Birth:	
	3. Name	of insured:				
	<u> </u>	MEDICAL INFORMATION				
5. Nature of injury or illness:		6. If accident, date of injury, or if illness, date of first symptoms:				
7. How did the accident happen?						
8. Where did the accident happen?			9. Was the accident work-related?			
10. Name of doctor who first treated patient for this condition:	11. Doctor's address and phone number:		Yes No 12. When was the patient first treated?			
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described in this authorization. St receive and use the information to Medical Records for diagnosis and	andard Life determine p I treatment	rein to be true. I hereby authorize to and Accident Insurance Company beayment or for other health care ope during the last five (5) years. Health for Release of Health Information expenses.	or its / rations. th Infor	Agent acting on the control of the c	on its be zation is e used f	half is authorized to for the release of all or Claim Processing
Signature		Date		Tel. No		
Address				2:		
Street		City		Sta	ie	Zip
THIS FORM MUST BE SIGNED B	Y THE PAT	TIENT. A PARENT OR LEGAL GUA	ARDIAN	N MUST SIGN	IF PATI	ENT IS A MINOR.
Any person who knowingly and	with inten	FRAUD NOTICES t to defraud any insurance compa	any or	other person	files a	n application for or

statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. Alabama and California residents: Any person who knowingly presents a false fraudulent claim for the payment of loss is quilty of a crime and may be subject to fines and confinement in state prison. Colorado residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. District of Columbia residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. Florida residents: Any Person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. New York residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.