



**Beech Street
Preferred
Provider Network
Plan**

**MAIL FORM TO:
Klais & Company, Inc.
Benefit Consultant and Administrators
1867 West Market Street
Akron, Ohio 44313-6977
Tele: 800-331-1096**

**Combined Life Insurance
Company of New York**

TO BE COMPLETED BY STUDENT

1. School Name: _____ Policy #: _____
2. Insured Student: _____ Group #: _____
3. Local Address: _____
4. Home Address: _____
5. Date of Birth: ____/____/____ Local Phone: _____ Home Phone: _____
6. Patient Status: Male Female Single Married Plan Member ID _____
- Is this Claim for a dependent? Yes No If yes, give name: _____
- Relationship: _____ Date of Birth: _____

COMPLETE THIS SECTION FOR ACCIDENT CLAIM

7. Is this claim the result of an accident? Yes No If yes, give date of accident: ____/____/____ Time of Accident: _____
8. Is this claim the result of a work-related injury? Yes No
- Is this claim the result of an auto accident? Yes No
- Is this claim the result of sports participation? Yes No If "yes" intercollegiate intramural club other
9. Where did the accident occur? _____
- How the accident did happen? _____

COMPLETE THIS SECTION FOR SICKNESS CLAIM

10. Name of physician: _____ Date of initial service: ____/____/____
11. Description of illness: _____
12. Has the patient been treated for the above condition(s) in the last 12 months? Yes No
- If "yes" give condition(s) treated for and date(s) of treatment: _____

COMPLETE THIS SECTION FOR ALL CLAIMS (ACCIDENT OR SICKNESS)

13. Is patient covered for benefits by any Group Health, Employer, Union, Welfare Plan or Parent Health Plan? Yes No
- Other coverage provided through: Name of Person _____ Relationship _____
- If answered "yes" please complete the following:
- Insurance Co. or Benefit Plan _____ Employer or Sponsor _____
- Address _____ Address _____
- Telephone: _____ Telephone _____
- Policy # _____ Please include a photocopy of other plan identification card, if available

14 To be completed regardless of age of patient:

- Is patient covered under MEDICARE Hospital Insurance (Part A) Yes Eff. Mo. ____/Day ____/Yr. _____ No
- Is patient covered under MEDICARE Hospital Insurance (Part B) Yes Eff. Mo. ____/Day ____/Yr. _____ No

15. 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. For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Insured Student _____ Date _____ 20 _____

Patient's or Authorized Person's Signature _____ Date _____ 20 _____

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 _____