First Health & 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

United States Fire Insurance Company

TO BE COMPLETED BY INSURED PERSON

1. **Plan Name:** COMPASS World Premium **Policy #:** ____________
2. **Insured Person:** ____________ **Group #:** ____________
3. **U.S. Address:** ____________
4. **Home Address:** ____________
5. **Date of Birth:** ____/____/____ (MM DD YYYY) **Local Phone:** ____________ **Home Phone:** ____________
6. **Patient Status:** ☐ Male ☐ Female ☐ Single ☐ Married **Plan Insurance ID** ____________

   Is this Claim for a dependent? ☐ Yes ☐ No **If yes, give name:** ____________

   Relationship: ____________ **Date of Birth:** ____/____/____ (MM DD YYYY)

COMPLETE THIS SECTION FOR ACCIDENT CLAIM ____________

7. **Is this claim the result of an accident?** ☐ Yes ☐ No **If yes, give date of accident:** ____/____/____ (MM DD YYYY) **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 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? ____________

   Name of Sport: ____________

COMMENTS/REMARKS BY SCHOOL AUTHORIZED ADMINISTRATOR ____________

Policyholder/SchoolSignature: ____________ **Date:** ____________:

COMPLETETHIS SECTION FOR SICKNESS CLAIM ____________

10. **Name of physician:** ____________ **Date of initial service:** ____/____/____ (MM DD YYYY)
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 (including Medicare) 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**

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 Person ____________ **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