CLAIM REIMBURSEMENT FORM

Please complete the information below and attach all bills pertaining to this particular claim only. Use separate claim form for each different dependent. Remember to affix the correct postage and mail to:

Assured Benefits Administrators
P.O. Box 211517
Eagan, MN 55121
or
Fax to (915) 532-0159

Employee Name_____Employer_____

Employee's Soc. Sec. No._____

Address_____City, State, Zip_____

Claim is for: Employee[ ] Spouse [ ] Child [ ] Claimant's date of birth:_____

Does the claimant have other health coverage? Yes [ ] No [ ] If yes, give name of

Other insurance carrier_____ Elig. Dates_____

Claim is being filed as a result of: illness [ ] accident [ ] maternity [ ] new born [ ]
Well patient [ ] dental [ ] vision [ ]

If illness, give date symptoms first appeared_____

Give date you first consulted a physician for this illness_____

If accident, give details_____
_____

I authorize payment of medical benefits to the provider of services. Yes [ ] No [ ]

Signed _____ Date_____

Please attach all receipts