



P O Box 10704
Springfield, MO 65808

Health Claim Form

Section 1 TO BE COMPLETED BY EMPLOYEE (Please answer ALL Questions that apply)

Employee's Name _____ S.S.N. _____

1. Employee's Date of Birth ____/____/____ Phone Number _____

2. Employee's Address _____
Street City State Zip

3. Name of Employer (Firm Name) _____

4. Date employed ____/____/____ Are you still employed full time? Yes No Single Married

5. Patient's Name _____ Date of Birth ____/____/____

6. Patient's Relationship to Employee
 Self Spouse Child (under 19) Full time student (over 18) Handicapped Other

7. If Claim is on Student over 18, Name & Address of School: _____
Has a Student Status Form been completed? Yes No Credit Hours: _____

8. Was your spouse employed during the past 12 months? Yes No
If "Yes," give name & address of Employer _____

9. OTHER HEALTH INSURANCE Do you, your spouse, whether married or divorced, or any of your dependent children have any other insurance described below? PLEASE CHECK ALL YES OR NO
Employer Yes No Any Government Plan Yes No If Yes to "any other"
Union Yes No Any Association Plan Yes No please explain and
School Policy Yes No Any other Yes No answer #10.

10. If the answer to any of the above is "Yes," please indicate name of the insured person and name of the Company providing benefits.
Name of Insured Person _____ Name, Phone & Address of Company or Organization _____ Policy # _____
_____/_____/_____ Date of Birth _____ Policy Type
Group _____ Auto _____
Individual _____

11. Complete When Accident is Involved:
Date of Accident ____/____/____ Location of Accident _____
Describe accident in detail _____
Was this accident related to your employment? Yes _____ No _____ If "Yes" explain _____

12. Complete When Sickness is Involved:
Nature of Sickness _____
Date symptoms first appeared _____
Was sickness related to your employment: Yes _____ No _____ If "Yes" explain _____

I certify that the above information is true and correct. I hereby authorize all DOCTORS, HOSPITALS, or other institutions rendering care & treatment to furnish FirstChoice Administrators with full information regarding treatment rendered (including copies of their records); I also authorize FirstChoice Administrators to obtain from or release to any Union Trust Fund, Employer, or Insurance Carrier all information regarding benefits to which I or my dependents, may be entitled and for these organizations to release to FirstChoice Administrators any such information.

Date _____ Employee Signature _____ Spouse Signature _____
(only if claim is on Spouse or there is other Insurance)

Assignment of Benefits (Complete this section only if you want us to pay the HOSPITAL, DOCTOR or other Medical Supplier DIRECT.)

I hereby authorize payment directly to the provider of services and I understand I am financially responsible for the Hospital, Medical or Physician charges not covered by this authorization.

_____/_____/_____ Date Employee Signature
2008-06