



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 Policy #: UCL3334S
2. Insured Person: Group #: ISO334
3. U.S. Address:
4. Home Address:
5. Date of Birth: U.S. 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 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:

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 (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 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