



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 Policy #: _____

2. Insured Person: _____ Group #: _____

3. U.S. Address: _____

4. Home Address: _____

5. Date of Birth: ____/____/____ 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: ____/____/____

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: _____

COMMENTS/REMARKS BY SCHOOL AUTHORIZED ADMINISTRATOR

Policyholder/SchoolSignature: _____ Date: _____

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 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 _____