

**CLAIM FORM
GROUP POLICY
285630**



<input type="checkbox"/> CHECK HERE IF NEW ADDRESS SINCE LAST SUBMISSION. DATE RELOCATED ____/____/____
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FORWARD COMPLETED CLAIM FORM TO: **FOREIGN SERVICE BENEFIT PLAN**
1620 L STREET, NW, SUITE 800
WASHINGTON, DC 20036-5629

Phone: (202) 833-4910

PLEASE PRINT

TO BE COMPLETED BY INSURED MEMBER
All items must be answered in full before your claim can be processed.

PLEASE PRINT

Member's full name _____ Sex _____ Date of Birth _____
 Member's mailing address _____
(Number and Street) (City) (State) (Zip Code)
 Member's Subscriber ID _____ Enrollment Code Self Only 401 Self Plus One 403 Self & Family 402
 If claim is for a dependent, given name _____ Relationship _____ Date of Birth _____
 Dependent's marital status (check one) single married
 Name of dependent's employer _____
 Describe Sickness/Accident Suffered _____
 If Accident: (a) Date of accident _____
(Month) (Day) (Year) (Hour)
 (b) How and where did accident occur? _____
 Was accident or sickness work related? Yes No If "Yes" please contact your workers' compensation office for guidance.
 Physician's Name _____ Address _____

OTHER INSURANCE/MEDICARE COVERAGE INFORMATION
(See section on coordination of benefits in your Brochure)

IMPORTANT: This question must be answered and the form signed before claim can be processed.

(a) Are you or any member of your family covered under any health plan other than FOREIGN SERVICE BENEFIT PLAN? Yes No
 (b) If answer is "Yes", complete the following:
 Person in whose name the other plan is issued _____
 Name of all dependents covered under the other plan _____
 Name of Insurance Company or Plan _____ Effective Date _____
 Address of Claims Office _____
 Is this insurance through active employment? _____ Employment Effective Date _____
 Policy or Contract Number _____ Is Plan Family or Self only coverage? (Check appropriate block)
 (c) Is this other plan issued under a Group or Individual contract? (Check appropriate block)

IMPORTANT: This question must be fully answered by persons age 65 or older and persons under age 65 receiving disability benefits through Social Security.

Medicare coverage (see your official Brochure)

(a) Are you or any member of your family covered under Medicare? Yes No
 (b) If "Yes", indicate name of person and check the type of coverage.
 SELF: _____ Hospital (Part A) Effective Date _____ Medicare (Part B) Effective Date _____
 SPOUSE: _____ Hospital (Part A) Effective Date _____ Medicare (Part B) Effective Date _____
 DEPENDENT: _____ Hospital (Part A) Effective Date _____ Medicare (Part B) Effective Date _____
 (c) If you or your spouse are 65 or over, indicate whether you are actively employed.
 Self: Yes No Employer _____
 Spouse: Yes No Employer _____

Authorization for direct payment of benefits.	I authorize payment directly to _____ <small>(Print name of physician)</small> for the Medical and/or Surgical Benefits otherwise payable to me. Date _____, 20____ Signed _____ <small>(Signature of member)</small>
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I certify the information on this form is complete and accurate.

Signature of patient or member	Date
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WARNING: Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000, or imprisonment of not more than five years, or both. (18 U.S.C. 1001)

HAVE YOU ANSWERED EVERY QUESTION? _____ HAVE YOU DATED AND SIGNED THIS FORM? _____