



Supplemental Medical Expense Insurance

# Claim Form

(Policy does not allow assignment of benefits)

**Administered by:**  
Key Benefit Administrators, Inc.  
PO Box 639  
Fort Mill, SC 29716-0639  
1-866-387-3402 (Toll-Free) / 1-866-408-6643 (Fax)

**To File A Claim:** Complete Sections 1 and 2 – Attach an itemized bill or have the Provider/Attending Physician complete Section 3 – Submit the Claim Form with the itemized bill attached (if applicable) to the address above with an Explanation of Benefits (EOB) from your primary medical carrier for these specific expenses.

## SECTION 1 - EMPLOYEE INFORMATION

_____	_____	_____	_____	_____
Last	First	Middle Initial	Gender	Certificate Number (See Certificate)
_____			(____) _____ - _____	(Ext. _____)
Address – Street & Number			Telephone #	
_____	_____	_____	_____	
City	State	Zip	Employee Social Security Number	
Group Number: (6 - 10 characters)				
Date of Birth ____/____/____		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		
<b>G</b> _____				

## SECTION 2 - PATIENT'S INFORMATION

_____	_____	_____	Date of Birth ____/____/____
Last	First	Middle	
Patient's Social Security Number: _____			
Relationship to Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other			
Date of Accident (if applicable) ____/____/____			
If auto accident, was patient ___Driver ___Passenger ___Unknown			
Is this accident/illness covered by Worker's Compensation? ___Yes ___No			

### Mandated Fraud Statement

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

Signature of Patient (If minor, parent/guardian must sign) \_\_\_\_\_ Date \_\_\_\_\_

Please attach an itemized bill: HCFA 1500 or UB92 with itemization or have Section 3 completed by the Attending Physician

SECTION 3 - ATTENDING PHYSICIAN STATEMENT (without itemized bill)

Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same authority as the original.

I hereby request and authorize you to furnish to Fidelity Life Insurance Company or its representative any and all medical information concerning any illness or injury I may have suffered.

X

Signature of Patient (If minor, parent must sign) \_\_\_\_\_ Date \_\_\_\_\_

**(Expires six months from this date unless indicated or revoked earlier.)**

If signed on behalf of another, indicate your relationship \_\_\_\_\_  
(Only if patient is unable to sign)

Name & Address of Facility where Services Rendered

If auto accident, was patient \_\_\_Driver \_\_\_Passenger \_\_\_Unknown?  
Is this accident/illness covered by Worker's Compensation? \_\_\_Yes \_\_\_No.

Diagnosis or Nature of Illness or Injury. Relate Diagnosis to Procedure in Column D by Reference to Numbers 1, 2, 3, Etc. or DX Code:

A Date of Service	B Place of Service	C Fully Describe Procedures, Medical Services or Supplies Furnished for each Date Given		D Diagnosis Code	E Charges	F	
		Procedure Code (Identify)	Explain Unusual Services or Circumstances				
					:		
					:		
					:		
Your Patient's Account No.				Total Charge	:	Amount Paid	Balance Due
					:		

Physician's Name (Please Print) \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Street Address) (City or Town) (State) (Zip Code) (Area Code - Phone)

Tax Identification Number Or Individual Social Security Number \_\_\_\_\_

