IMPORTANT - READ CAREFULLY

1. Fill out Employee section.
2. Answer all questions to assure prompt service of your claim.
3. Attach all itemized bills not previously submitted.
4. **Sign the form.**

NOTE: THIS FORM MAY BE RETURNED IF NOT SIGNED!

SUBMIT COMPLETED FORM AND BILLS PROMPTLY TO:

naa | North America Administrators

P.O. BOX 1984
NASHVILLE, TN 37202

MEDICAL CLAIM FORM

TO BE COMPLETED BY EMPLOYEE

ANSWER ALL QUESTIONS THAT APPLY.
SIGN WHERE INDICATED BY ☛

Employee's Full Name	Employee Marital Status	M. / S. / Wid.	Div. / Legal Sep.	❑ Male ❑ Female	Date of Birth	Soc. Sec. Number

Home Address *(Number and Street)* *(City)* *(State)* *(Zip Code)*	Telephone Number
Email Address	

Employed by	Occupation	Date Employed

Name of Group

Claim is made for ❑ Self ❑ Dependent	Dependent's Name	Dependent's Marital Status	M. / S. / Wid.	Div. / Legal Sep.	❑ Male ❑ Female	Date of Birth	Relationship to Insured

Describe Disability

IF CLAIMANT WAS INJURED	Time: ❑ A.M. ❑ P.M.	Was claimant at work when the accident occurred? ❑ Yes ❑ No	Name of Employer
Date accident occurred	Describe accident. (Tell how, when and where it occurred.)		
Was illness caused by work? ❑ Yes ❑ No	Has there been or will there be a claim filed for injury or illness with the workman's compensation carrier? ❑ Yes ❑ No		

Name of your spouse	Spouse's Birthdate	Spouse's Soc. Sec. #	Is spouse employed? ❑ Yes ❑ No Name, address and phone number of your spouse's employer

Does your spouse have any insurance at his/her place of employment? ❑ Yes ❑ No	If "Yes," give name and address of the insurance company.

Please provide names of all family members who are covered under this insurance and provide a copy of the insurance card:

Are you or any of your dependents covered under any other insurance plan other than as shown above or under any federal, state or other governmental program? ❑ Yes ❑ No	If "Yes," give name and address of the insurance company and provide a copy of the insurance card.

Please provide names of all family members who are covered under this insurance:

Are you or your spouse covered under Medicare? SELF: ❑ Yes ❑ No SPOUSE: ❑ Yes ❑ No If "Yes," provide a copy of the Medicare card.	Do you or your spouse have more than one employer? If "Yes," give names and addresses of all employers.

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish North America Administrators, L.P. with full information regarding treatment rendered (including copies of their records). I/We also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish North America Administrators, L.P. with information regarding benefits to which I/We may be entitled. **(If claim for spouse, spouse also must sign.)** A copy or photocopy of this authorization shall be considered as effective and valid as the original.

Date	Employee's Signature ☛	Spouse's Signature ☛

PLEASE BE SURE ALL BILLS NOT PREVIOUSLY SUBMITTED ARE FORWARDED WITH THIS CLAIM FORM.