IMPORTANT - READ CAREFULLY

1. Please complete this form in its entirety.
2. Indicate "Not Applicable" or "N/A" if a section does not apply.
3. Be sure to sign and date this form at the bottom.

Note: This form may be returned if not properly completed and signed.

naa North America Administrators

P.O. Box 1984 Nashville, TN 37202

HEALTH PLAN CLAIM FORM

Section I: Employee Information

Employee's Full Name	Employee Marital Status	Gender	Date of Birth	Soc. Sec. Number
	Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐	Male ☐ Female ☐		

Home Address *Number & Street* *City* *State* *Zip Code*

Email address	Telephone Number

Employer	Group or Plan #	Occupation	Date of Employment

Section II: Claimant (patient) Information

Patient's Name	Patient Marital Status	Gender	Date of Birth	Who is the patient?
	Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐	Male ☐ Female ☐		Self ☐ Spouse ☐ Child ☐

Section III: Other Insurance Coverage Information

Does your spouse have insurance at his/her place of employment? Yes ☐ No ☐	Spouse's Name	Date of Birth	Soc. Sec. Number

Name and phone number of spouse's employer:

Name and phone number of insurance company:

Please provide names of all family members covered under your spouse's insurance and provide a copy of the front and back of the I.D. card.

Do you or any family members have more than one employer? If yes, list name of family member, their Employer's name and phone number.

Are you or any family members covered under any insurance plan not listed above or under any federal, state, or other governmental program (i.e. Medicaid, CHIP, etc.)? Yes ☐ No ☐ If "yes" please provide names of those covered:

Are you or any family members covered under Medicare? Yes ☐ No ☐ If "yes" list the name of the family member and provide a copy of the front and back of the Medicare card.

Section IV: Accident, Injury, or Work Related Illness Information

Is your medical claim due to an accident, injury or work related illness? Yes ☐ No ☐ If "no", skip to section V.	Date Accident/Injury Occurred:	Did accident/injury happen at work? Yes ☐ No ☐ Was illness work-related? Yes ☐ No ☐

Describe accident or injury (tell how, when, and where it occurred).

Section V: Authorization & Signature

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 or adult dependent child, they also must sign). A copy or photocopy of this authorization shall be considered as effective and valid as the original.

Employee Signature	Spouse/Adult Dependent Child Signature	Date