NEXCALIBER
P.O. BOX 802422, DALLAS, TX 75380-2422
GROUP HEALTH BENEFITS

EMPLOYEE'S STATEMENT

EMPLOYEE SOCIAL SECURITY #

Employee Data

Employee's Name:
Address:
Street
City State Zip Code

Date of Birth:

☐ Male ☐ Female

☐ Married ☐ Single ☐ Divorced ☐ Widow(er)

Telephone Number:

*Date on which you (employee) last worked preceding claim
Month Day Year

If claim for employee, give date employee became totally disabled
Month Day Year

*Information needed on dependent and employee claims to determine coverage

Other Group Coverage Data

Is patient under *any other group insurance plan?* ☐ Yes ☐ No If "yes", give name and address of union, association or company and Policy number.

Name of Spouse Date of Birth

Is your *spouse* employed? ☐ Yes ☐ No If "yes", by whom?
Name and Address of Employer

Name and address of such employer's insurance Company. Policy Number

Does your *spouse* carry this insurance? Does your *spouse* carry dependent's coverage?

Dependent Data (To be completed only if patient is a dependent)

Patient's Name Address

Relationship ☐ Child ☐ Spouse

Date Of Birth

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widow(er)

Is patient a child over age 19 and a full time student? ☐ Yes ☐ No If Yes, please provide Student Status Verification Form.

Is child-patient employed? ☐ Yes ☐ No If "yes" ☐ Part time? ☐ Full time?

Claim Data

Describe condition or illness

Give date symptoms began
Month Day Year

If illness, has patient ever had same or similar illness? ☐ Yes ☐ No If "yes", give date last treated

and name(s) and address(es) of attending physicians

Did condition result from accidental injury? ☐ Yes ☐ No If "yes" give: Date: Mo Day Yr Hour: ☐ A.M. ☐ P.M. Place: Home, work, highway, etc.

State how accident happened

I agree to reimburse Nexcaliber and/or The Plan if this claim for sickness/injury is compensable under Medicare, Workman's Compensation Act, or other similar law or if such claim is settle or compromised, or if benefits excluded by the non-duplicating provisions of the contract are paid.

I hereby authorize any physician, hospital, insurance company, service plan, employer, organization or association to release to Nexcaliber or any party acting on their behalf any information regarding medical history, treatment, disability, or benefits paid or payable for this claim. A copy of this authorization shall be valid as the original.

Except where my Plan provides for automatic payment of benefits to the provider of services, I authorize payment of benefits, otherwise payable to me for services rendered by those physicians or providers described above and/or on the enclosed bills. I understand that I am financially responsible to the provider for charges not covered by my benefit Plan.

Employee Signature Date Signed
Signature necessary on all claims

Signature of Patient Date Signed
Required only if patient is spouse