

statement of health

Employee Benefit Services

CLAIM NUMBER
_____ - _____ - _____ - _____

to be completed by member			
INSURED EMPLOYEE'S NAME		INSURED EMPLOYEE'S IDENTIFICATION NUMBER	
INSURED EMPLOYEE'S STREET ADDRESS		CITY	STATE ZIP CODE
NAME OF EMPLOYER (GROUP POLICYHOLDER)		GROUP POLICY NUMBER	

to be completed by physician				
NAME OF DEPENDENT	SEX	DATE OF BIRTH	NATURE OF DISABILITY	DATES OF TOTAL DISABILITY
				FROM:
				TO:
				FROM:
				TO:
				FROM:
				TO:
				FROM:
				TO:
				FROM:
				TO:
PHYSICIAN'S NAME			PHYSICIAN'S TELEPHONE NUMBER	
PHYSICIAN'S STREET ADDRESS		CITY	STATE	ZIP CODE
PHYSICIAN'S IDENTIFICATION NUMBER	PHYSICIAN'S EMPLOYER I.D. NUMBER	SIGNATURE OF PHYSICIAN		
		X		

member signature

I hereby authorize my insurance company, prepayment organization, employer, hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or service. I certify that the information by me is support of this claim is true and correct. A copy of this authorization shall be valid.

X _____ DATE _____
SIGNATURE OF INSURED PERSON

Please return to: Attn: _____
Employee Benefit Services
P.O. Box 82669, Lincoln, NE 68501-2669 or fax to **402.309.2580**