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:
				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 ______________________________ ____________________

SIGNATURE OF INSURED PERSON DATE

Please return to: Attn: ______________________________

Employee Benefit Services

P.O. Box 82669, Lincoln, NE 68501-2669 or fax to **402.309.2580**

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