CLAIM REIMBURSEMENT **FORM**

ASSURED BENEFITS ADMINISTRATORS

Please complete the form below and attach all bills pertaining to this specific claim only. Use a separate claim form for each dependent. Send this form and all attachments through one of the methods listed below:

If sending by mail, mail to:
Assured Benefits Administrators
P.O. Box 211517
Eagan, MN 55121-2717

If sending by facsimile, fax to:
915-532-0159

If you have any questions, contact us at 1-800-247-7114. Our customer service representatives are available Monday through Friday from 8 a.m. to 6 p.m. Central Standard Time.

EMPLOYEE NAME _____ EMPLOYER _____

SSN _____ PHONE _____ EMAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CLAIM IS FOR: ☐ EMPLOYEE ☐ SPOUSE ☐ CHILD CLAIMANT'S DATE OF BIRTH _____

IF THIS CLAIM IS FOR A CHILD OVER 19 YEARS OF AGE, IS THE CHILD A FULL-TIME STUDENT? ☐ YES ☐ NO

*If **YES**,* SCHOOL NAME _____

DOES THE CLAIMANT HAVE OTHER HEALTH INSURANCE COVERAGE? ☐ YES ☐ NO

*If **YES**,* OTHER INSURANCE CARRIER _____ ELIGIBILITY DATES _____

REASON CLAIM IS BEING FILED: ☐ ACCIDENT ☐ MATERNITY ☐ NEWBORN ☐ WELL PATIENT ☐ DENTAL ☐ VISION

*If **ILLNESS**,* DATE SYMPTOMS FIRST APPEARED _____ DATE PHYSICIAN FIRST CONSULTED _____

*If **ACCIDENT**,* GIVE DETAILS _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER OF THESE SERVICES. ☐ YES ☐ NO

SIGNATURE _____ PRINT NAME _____

DATE _____

REMINDER: PLEASE ATTACH ALL RECEIPTS.