CLAIM REIMBURSEMENT FORM

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.