Group Plan Solutions
Benefit Administration
A Division of Pekin Insurance®

GROUP PLAN SOLUTIONS
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STATEMENT OF CLAIMS

All sections must be completed or form will be returned.

Employee's Name	Patient's Name	Patient's Date of Birth

Address	Telephone Number	Member ID Number

Is patient covered by any other insurance? ☐ yes ☐ no
If yes: Name & phone number of the other company _____

Type of Coverage _____ Effective Date _____

Policy No. _____ Social Security No. of Policy Holder _____

Please indicate what this treatment was for (Describe sickness or how injury occurred)_____

_____

Date symptoms began or injury occurred _____

Date first treated _____

Name & address of first doctor seen for this condition _____

Have you ever had a similar condition? ☐ yes ☐ no
If yes, prior doctor's name & address _____

Family doctor's name & address _____

Is this condition covered by a Worker's Compensation policy? ☐ yes ☐ no

Has a claim been filed with them? ☐ yes ☐ no Name of Employer _____

AUTHORIZATION

GROUP PLAN SOLUTIONS or its representatives are hereby authorized to examine and secure copies of any medical records, including information relating to mental illness, and drug and alcohol use, employment records, governmental records, records of other insurance companies, or other records or information. A copy of this authorization shall be considered as valid as the original.

I understand that such information will be used by Group Plan Solutions for the purpose of evaluating my claim for plan benefits. I or any authorized representative will receive a copy of this authorization upon request.

This authorization is valid for the date signed for the duration of the claim.

DATE _____ **SIGNED** _____

(If Patient/Employee is under eighteen (18) years of age or is incapacitated, Parent or Guardian must sign. If Patient/Employee is deceased, Personal Representative or Next of Kin must sign.)