GILSBAR
Insurance Services

CLAIM FORM

PLEASE COMPLETE FULLY AND ATTACH THIS FORM TO ALL CONTINUING BILLS AND/OR CORRESPONDENCE.

GROUP NUMBER: **S-5002** MEMBER ID #: _____

EMPLOYEE: _____

CLAIM FOR: _____ SELF _____ DEPENDENT

DEPENDENT NAME _____ RELATIONSHIP _____

PLEASE GIVE DETAILS IF THE CHARGES ARE IN RELATION TO AN ACCIDENT:

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DATE _____ EMPLOYEE'S SIGNATURE _____