BENEFIT CONCEPTS INCORPORATED

PO BOX 60608
KING OF PRUSSIA
PA 19406-0608

610-337-2600

CLAIMS INFORMATION SHEET

Group Name: _____

Group Number: _____

COMPLETION OF THIS INFORMATION WILL HELP TO AVOID UNNECESSARY CLAIM DELAYS

EMPLOYEE INFORMATION:

EMPLOYEE NAME:	**EMPLOYEE IDENTIFICATION NUMBER:**

VERIFICATION OF OTHER MEDICAL COVERAGE:

I certify the following information with regard to medical coverage under another group insurance plan:

Is the employee covered by another group medical plan? ☐ Yes ☐ No

Effective date of employee's medical coverage? _____/_____/_____ Termination date _____/_____/_____

Is the employee covered by another group dental plan? ☐ Yes ☐ No

Effective date of employee's medical coverage? _____/_____/_____ Termination date _____/_____/_____

Is the employee eligible for Medicare? ☐ Yes ☐ No

Effective date Part A? _____/_____/_____ Effective date Part B _____/_____/_____

Employee Current Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other ☐ Specify _____

DEPENDENT INFORMATION:

SPOUSE NAME:	**SPOUSE'S DATE OF BIRTH (mm/dd/yyyy):**

Are dependents covered by another medical insurance? ☐ Yes ☐ No

If yes:
Name of principal insured: _____

Name of the insurance company: _____

Address: _____

_____

_____

Group Number: _____ Effective date of dependent coverage? _____/_____/_____

Termination date of dependent coverage?_____/_____/_____

Are dependents covered by another dental insurance? ☐ Yes ☐ No

If yes:
Name of principal insured: _____

Name of the insurance company: _____

Address: _____

_____

_____

Group Number: _____ Effective date of dependent coverage? _____/_____/_____

Termination date of dependent coverage?_____/_____/_____

Are dependents eligible for Medicare or any other government program? ☐ Yes ☐ No

If yes:
List Dependents: _____

_____

Effective date of coverage? _____/_____/_____

DEPENDENT INFORMATION (continued):

If you have selected single, divorced, or separated as the employee status on the previous page, please complete the information below with regard to dependent children:

Complete name of natural Father: _____

Address: _____

_____

_____

Full Name of natural Father's Employer: _____ Date of Birth ____/____/____

Address: _____

_____

_____

Does the natural Father's Employer provide medical coverage for the dependent? ☐ Yes ☐ No
Does the natural Father's Employer provide dental coverage for the dependent? ☐ Yes ☐ No

If yes, please provide the name, address and phone# of the insurance carrier: _____

_____

Complete name of natural Mother: _____

Address: _____

_____

_____

Full Name of natural Mother's Employer: _____ Date of Birth ____/____/____

Address: _____

_____

_____

Does the natural Mother's Employer provide medical coverage for the dependent? ☐ Yes ☐ No
Does the natural Mother's Employer provide dental coverage for the dependent? ☐ Yes ☐ No

If yes, please provide the name, address and phone# of the insurance carrier: _____

_____

Is there a court decree establishing the custody of the dependent along with a provision for medical and dental benefits? ☐ Yes ☐ No

If yes, please advise which parent has custody and forward a copy of the specific page from the decree addressing custody and benefit responsibilities for our records. _____

(Information regarding other coverage will be verified every 12 months)

FULL TIME STUDENT INFORMATION:

Verification of full time student status will be requested at the time of claim. The Claim Department will require proof of student status in order to process claims. Student status verification will be required once each semester. The following types of documentation are acceptable:

- completed form from the registrars office (sample attached)
- screen print of the student's online access to the registrars office verifying semester schedule and credit hours
- report card containing credit hours and semester attendance
- letter from registrar's office confirming semester and full time attendance
- registration card showing the claimant is a full time student during the period in question

HIPAA CERTIFICATE OF CREDITABLE COVERAGE (Pre-Existing Conditions):

Your plan contains a pre-existing clause which may result in claim delays during the initial probationary period of the program. If you or your dependents have not been covered under the program for at least 12 or 18 months (refer to plan document), additional information will be required to determine available coverage. At the time of claim, letters will be sent to you and your health provider to determine if the condition was pre-existing. If you are able to provide a Certificate of Creditable coverage, the pre-existing period will be reduced by the employee's or dependent's period of creditable coverage as of the enrollment date in the Plan. Days of creditable coverage that occur before a significant break in coverage are not counted toward the pre-existing condition exclusion.

Signature: _____ Date: _____