Mail Completed Form to:

Chesterfield Resources, Inc.
PO Box 1884
Akron OH 44309
Toll Free 1-800-432-4845

THE SALVATION ARMY
Western Territory
Officer Health Plan

CONTROL NO. 6100

SICK BENEFIT APPLICATION FORM

INSTRUCTIONS:

1. Photocopies are not acceptable. All charges must be fully itemized on the original bill. Assignments of benefits to the provider will be honored by completing item 10.
2. It is not necessary to pay your bills before submitting them for reimbursement, with the exception of Assisted Living bills. These bills must be paid in full by the patient and paid receipts submitted to Chesterfield. **Please Note:** Except for Skilled Nursing Home care, all expenses for residential care or in-home nursing care must be paid before submitting to Chesterfield for reimbursement.
3. All expenses applicable to Medicare should be submitted to Medicare first, the itemized bill with the explanation of Medicare benefits should be submitted to Chesterfield Resources, Inc.
4. All family members may be submitted on one form.

PLEASE PRINT OR TYPE

☐ **NUMBER OF ITEMS ATTACHED**

1. Head of Household	First	Last	Social Security Number	Birthdate Mo. Day Year
2. Home Address	Number	Street	City / State / Zip Code	Is This A New Address? YES ☐ NO ☐

3. Claimants Name(s)	First	Last	Social Security Number	Sex	Birthdate Mo. Day Year
A.					
B.					
C.					

4. Is Officer					Is Claimant Enrolled in Medicare?
ACTIVE ☐ (100)	RETIRED ☐ (200)	AUX CAPT ☐ (300)	RETIRED AUX CAPT ☐ (400)	HOMELAND ☐ FURLOUGH (900)	NO ☐ YES ☐

IF EXPENSES ARE THE RESULT OF AN ACCIDENTAL INJURY, COMPLETE ITEMS 5-8

5. Injured Claimant's Name		Relationship to Head of Household
6. Date of First Treatment For This Injury	Nature of Injury	
7. Is This Condition Due to an Auto Accident? NO ☐ YES ☐	Date of Accident	Where and How Did Accident Occur?
8. Is Injury Work Related? NO ☐ YES ☐	If Yes, Describe How and Where Injury/Illness Occurred:	

9. AUTHORISATION FOR RELEASE OF INFORMATION

In consideration of benefit payment under this health plan, without reduction for any right to recovery, I assign to Chesterfield Resources, Inc., my right and title to any recovery for this disease and injury, however recovered, to the extent of benefits paid under this health plan.

I authorize Chesterfield Resources, Inc., its agents, attorney, or designee, (collectively referred to as "Chesterfield"), to obtain any information necessary to make any determination as to eligibility, continued eligibility or extent of eligibility, of a claim for benefits under the terms of a health plan, without the consent or notice to any person, including but not limited to a covered individual. I authorize any physician, hospital, insurer, plan, employer, administrator, or other health care provider or professional to disclose any medical, psychological, and employment-related information, to Chesterfield so such determination may be made.

I recognize I have a right to receive a copy of this authorization and that a photographic copy of my signature is as valid as the original.

Claimant Signature ____________ Officer Signature ____________ Date ____________

10. AUTHORIZATION TO PAY PROVIDER

Sign here only if benefits are to be paid directly to the physician, hospital, or other provider of medical care.
I authorize payment of medical benefits to physician or supplier for services described on the attached bill:

Claimant Signature ____________ Officer Signature ____________ Date ____________