

THIS FORM SHOULD BE COMPLETED BY THE POLICYHOLDER

Policy Number _____

TO AVOID DELAY IN THE PROCESSING OF YOUR CLAIM, PROMPTLY RETURN THIS COMPLETED AND SIGNED FORM. THANK YOU.**Section 1 - PERSONAL INFORMATION**

Insured's Name _____ Social Security No. _____ Date of Birth _____

Patient's Name _____ Social Security No. _____ Date of Birth _____

Address _____ Phone No.(Day/Work/Cell) _____

Are you or any of your family members covered by any other health plan, Medicare or other government plan? _____ If Yes, complete the following:

Covered person's name _____ Relationship to you _____ Name of health insurance company and address _____

_____ Policy No. _____

Section 2 - IF YOUR CONDITION WAS CAUSED BY SICKNESS, ANSWER THESE QUESTIONS:

For what sickness or disease were you treated? _____

On what date were symptoms first noticed? _____ On what date did you first consult a doctor? _____

Have you been treated for the same condition within the last 5 years? _____ If yes, indicate date treatment began _____ and the date you were last treated _____

_____ Were you referred by another physician or health care provider? _____ If yes, name, address and phone no. _____

Section 3 - IF YOUR TREATMENT WAS CAUSED BY INJURIES, ANSWER THESE QUESTIONS:

When did the accident occur? At _____ o'clock _____ on _____, 20____ Accident or illness due to employment? _____ If yes, name of employer, address and phone no. _____ Occupation _____

Injury due to auto accident? _____ How did the accident occur? _____

Where did the accident occur? _____ Did any police officer investigate the accident? _____

If yes, please submit a copy of the POLICE REPORT. If yes, name of the Agency _____ City/State _____

Names of witnesses to the accident with addresses and phone numbers: _____

If anyone else was injured give the names, addresses and phone numbers _____

Did any person, product or property hazard cause or contribute to the injuries? _____ If yes, who or what? _____

Have you had contact with any investigator or adjustor from the other person(s) firm or insurance company? _____ If yes, date(s) of contact _____

If yes, name, address and phone number _____

Did you give a statement? _____ Did you provide information regarding the accident? _____ Has a release been signed? _____ If yes, date _____

If you are represented by a lawyer give the name, address and phone no. _____

Section 3 (continued) - WAS THE INJURY SUSTAINED AT A SCHOOL OR WHILE PATIENT ENGAGED IN ANY ATHLETIC, SPORTS OR RECREATIONAL ACTIVITY? _____

If yes, list the name of school or school-sponsored event, address and phone number _____

If the injury occurred at a sporting event list the name of the sponsor, address and phone number _____

If the injury occurred at a commercial sporting or recreational facility, give the name, address and phone number _____

Section 4 - IN ORDER TO PROPERLY CONSIDER THIS CLAIM, IT IS NECESSARY FOR US TO OBTAIN A COMPLETE LIST OF NAMES, ADDRESSES AND PHONE NUMBERS OF ALL DOCTORS YOU HAVE SEEN IN THE PAST FIVE YEARS.

When filing your own claim, please include any itemized bill from providers (doctor, hospital, etc.). We cannot process from billing statements or receipts.

I CERTIFY THAT THE INFORMATION ON THIS CLAIM FORM IS FULL, COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON. TEXAS INSURANCE CODE ARTICLE 3.97-2.

I acknowledge that my health benefits plan is entitled to recover from any person or firm legally responsible for my injuries up to the amount of benefits the Plan pays for treatment of my injuries and I recognize that the Plan retains a lien on my claim against such responsible firm or person. I will not release any responsible party from liability without the Plan's written consent.

Signed by Patient, or Parent of a minor Patient _____ Date _____

Section 5 MEDICAL RECORDS AUTHORIZATION FORM

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996, 45 CRF§ 164.508. It authorizes Southwest Service Life Insurance Co. to use my complete medical records, and those of my family members whose names appear in my application for health insurance, for the purposes of insurance underwriting, risk review, claims adjudication and other health plan insurance operations.

The person/people/entities authorized to make this disclosure to Southwest Service Life Insurance Co. is/are my physicians, medical practitioners, hospitals, clinics, medical facilities or other health care providers having records or knowledge of my health, and those of my family members whose names appear in my application for health insurance.

The confidentiality of my healthcare information is waived by this authorization, which permits disclosure of any and all requested parts of my medical records. I understand that re-disclosure may not be protected. I understand this may include drug, alcohol, mental health, HIV or AIDS information.

This authorization is valid for two years following the date written below and will then expire. Under the Privacy Rules, I have the right to revoke this authorization at any time, and Southwest Service Life Insurance Co. must cease using this authorization. However, Southwest Service Life Insurance Co. may complete any actions it initiated prior to my revocation and which rely on my complete medical records for completion. I must revoke this authorization in writing and send the revocation to Southwest Service Life Insurance Co., P.O. Box 982005, Fort Worth, Texas 76182-8005.

Primary Policyholder Signature _____	Please complete, if applicable:	
Date _____	Print name of covered children _____	Date of Birth _____
Other Adult Signature _____	_____	_____
Date _____	_____	_____