



CLAIM FORM

Underwritten by:
Nationwide Life
Insurance Company

Submit to:
FRINGE BENEFIT COORDINATORS
1239 N.W. 10th Avenue
Gainesville, FL 32601
(352) 377-1239 8:30 am – 5:00 pm EST

PART 1 STUDENT STATEMENT **PLEASE REFER TO INSTRUCTIONS BELOW**

STUDENT NAME		SOCIAL SECURITY #	GROUP NUMBER	
STUDENT ADDRESS		STUDENT BIRTH DATE	EMPLOYER	EMPLOYER PHONE NO.
CITY		PHONE NO.	IS THE STUDENT A FULL TIME EMPLOYEE? YES <input type="checkbox"/> NO <input type="checkbox"/>	
STATE	ZIP		STUDENT STATUS: FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> SCHOLAR <input type="checkbox"/>	
DEPENDENT NAME		RELATIONSHIP	DATE OF BIRTH	IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT NAME		RELATIONSHIP	DATE OF BIRTH	IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT NAME		RELATIONSHIP	DATE OF BIRTH	IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DATE ACCIDENT OR SICKNESS BEGAN		NATURE OF SICKNESS, INJURY, DIAGNOSIS OR MEDICAL VISIT?		IS CONDITION WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?				
HAVE YOU BEEN TREATED FOR THIS ILLNESS OR INJURY IN THE LAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, NAME AND ADDRESS OF ATTENDING PHYSICIAN	
NAME AND SOC. SEC. # OF SPOUSE		BIRTHDATE	IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME AND ADDRESS OF SPOUSE'S EMPLOYER
IS THE STUDENT OR DEPENDENTS COVERED UNDER ANY OTHER MEDICAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO				
IF YES, COMPLETE THE FOLLOWING:				
PLAN NAME:		PLAN ID #:		
PLAN ADDRESS:		GROUP PLAN #:		EFFECTIVE DATE:
PATIENT OR PARENT MUST SIGN AND DATE BELOW			IF PAYMENT IS TO BE MADE TO PROVIDER(S), SIGN BELOW	
AUTHORIZATION TO RELEASE INFORMATION I hereby authorize any insurance company, prepayment organization, third party payor, employer hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits for service. I hereby certify the information provided is correct and true to the best of my knowledge.			AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S): I hereby authorize payment of benefits directly to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.	
X _____ Date _____ Student, or Parent if minor			X _____ Date _____ Student, or Parent if minor	

PROCEDURE FOR FILING A CLAIM

1. Complete and sign the "STUDENT STATEMENT" section of the form (Part #1).
 - It is important to know how, when and where your accident occurred.
 - Questions regarding other coverage you or your dependents are eligible for must be answered.
 - Student, or parent if minor, must always sign the "Authorization to Release Information". A claim cannot be processed without this authorization and verification.
 - If payment is to be made to the provider of services, you should sign that section.
2. Have your doctor complete the reverse side for each disability, diagnosis or treatment only when not accompanied by an itemized bill.
3. If you have other coverage (including Medicare), make sure you attach all payment statements or declination letters.
4. Attach all bills relating to the claim.
 - Make sure all bills identify the patient.
 - All bills should show the date of treatment, type of service, and amount of charges.
 - Drug bills must include name of patient, date filled, drug name, quantity and dosage, name of ordering physician.
 - Do not submit cash register tapes or cancelled checks.

PART 2		TO BE COMPLETED BY PHYSICIAN			
PATIENT'S NAME	BIRTH DATE OF PATIENT	DOES PATIENT HAVE OTHER COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE IDENTIFY		
DIAGNOSIS AND CURRENT CONDITIONS					
ICD-9					
HAS THE PATIENT EVER HAD THE SAME OR SIMILAR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", WHEN AND DESCRIBE.					
REPORT OF SERVICES (IF PREVIOUS FORM SUBMITTED, YOU ONLY NEED DATES AND SERVICES SINCE LAST REPORT) OR ATTACH ITEMIZED BILL.					
				CLAIMS OFFICE USE ONLY	
DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE USED	CHARGES	
			TOTAL CHARGES	\$	
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION		AMOUNT PAID	\$	
IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO	LAST DAY WORKED DATE		BALANCE DUE	\$	
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) FROM THROUGH	TYPE OR PRINT PHYSICIAN'S NAME:			<input type="checkbox"/> EIN <input type="checkbox"/> SSN	
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK	ADDRESS:		FEDERAL TAX ID NUMBER (REQUIRED FOR BENEFITS TO BE ASSIGNED)		
DATE STUDENT RETURNED TO WORK	CITY, STATE, ZIP CODE:				
PHYSICIAN'S SIGNATURE X _____		PHONE:		DEGREE:	

I authorize any physician, medical practitioner, hospital, clinic, other medical or related facility, insurance company or reinsurance company, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give NATIONWIDE LIFE INSURANCE COMPANY and Fringe Benefit Coordinators or its legal representative, any and all such information.

I understand the information obtained by use of this authorization will be used by NATIONWIDE LIFE INSURANCE COMPANY and Fringe Benefit Coordinators to determine eligibility of benefits under an existing policy. Any information obtained will not be released by NATIONWIDE LIFE INSURANCE COMPANY and Fringe Benefit Coordinators to any person or organization EXCEPT to reinsurance companies or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid during the pendency of this claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

DATE _____ 20 _____ SIGNATURE _____