

Teachers Health Trust

P.O. BOX 96238

LAS VEGAS, NEVADA 89193-6238

TEACHERS HEALTH TRUST

CLAIM FORM

ENROLLEE INFORMATION – ENROLLEE SHOULD COMPLETE THIS SIDE (TYPE OR PRINT)

1. INSURED'S NAME _____
FIRST MIDDLE LAST

2. SOCIAL SECURITY NUMBER - - GROUP NUMBER – 20660

3. HOME ADDRESS & TELEPHONE NUMBER CHECK IF NEW
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 STREET ADDRESS CITY STATE ZIP TELEPHONE NUMBER

4. BIRTHDATE: _____ SEX: MALE FEMALE
MONTH DAY YEAR

5. WORK STATUS: ACTIVE _____ RETIRED _____ OTHER _____
 (CHECK ONE & GIVE DATE)

PATIENT INFORMATION

6. PATIENT'S NAME _____ PATIENT'S SOC. SEC. NO. _____
FIRST MIDDLE LAST

7. RELATIONSHIP TO INSURED _____

8. PATIENT ADDRESS IF NOT SAME AS INSURED _____
STREET ADDRESS CITY STATE

9. BIRTHDATE: _____ SEX: MALE FEMALE
MONTH DAY YEAR

10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT? YES NO AN ACCIDENT? YES NO
 IF AN ACCIDENT, COMPLETE THE FOLLOWING: _____ AM PM
DATE OF ACCIDENT

11. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED: _____

FAMILY INFORMATION

12. DOES INSURED OR ANY FAMILY MEMBER HAVE OTHER HEALTH INSURANCE? YES NO

IF YES, COMPLETE THE FOLLOWING: NAME OF FAMILY MEMBER: _____ SSN: _____

TYPE OF INSURANCE: OTHER EMPLOYER SPONSORED PLAN OTHER GROUP SPONSORED PLAN

NAME & ADDRESS OF OTHER EMPLOYER OR GROUP: _____


MEDICARE PART A YES NO EFFECTIVE DATE _____
 PART B YES NO EFFECTIVE DATE _____

AUTHORIZATION TO RELEASE INFORMATION

AUTHORIZATION TO OBTAIN INFORMATION

I / We jointly certify that the above information is complete, true and correct.
 I / We hereby authorize all doctors, dentists, psychologists, pharmacists, hospitals or other institutions providing care, treatment, consultation, drugs or supplies to furnish TEACHERS HEALTH TRUST or its authorized representative with full information regarding history, physical or mental condition, consultation, treatment or psychotherapy rendered – including copy of their records.
 I / We authorize any insurance carrier, service plan, union, trust fund, or employer to furnish TEACHERS HEALTH TRUST with information regarding benefits to which I/we may be entitled.
 I / We authorize any college, university or other educational institution to furnish TEACHERS HEALTH TRUST with information determined necessary to TEACHERS HEALTH TRUST to establish student eligibility.
 I / We also authorize TEACHERS HEALTH TRST to release any information relevant to a determination of the implementation of a coordination of benefits provision to any insurance carrier, service plan, union, trust fund, or employer requesting such information. A photostatic copy of this authorization shall be considered as effective and valid as the original.

 DATE PATIENT'S SIGNATURE (Parent if Patient is a Minor)



PAYMENT AUTHORIZATION

I AUTHORIZE LPAYMENT TO BENEFITS DIRECTLY TO THE PHYSICIAN OR SUPPLIER NAMED HEREIN FOR THE SERVICES DESCRIBED

 INSURED OR AUTHORIZED PERSON'S SIGNATURE DATE

