INSURED REIMBURSEMENT MEDICAL CLAIM FORM

Standard Security Life

Claims Payment Services by Insurers Administrative Corporation

(Please Print)

Employer's Name:	Group No:

EMPLOYEE AND PATIENT INFORMATION

Employee's last name:	First:	Middle:	Employee's birth date: / /	Employee's Social Security no: ______ / ______ / _______

Patients last name:	First name:	Relationship to employee: ❑ Self ❑ Spouse ❑ Child	Patient's birth date: / /	Age:	Gender: ❑ M ❑ F

Home address:	Patient's Social Security no.:	Home phone no: ( )

P.O. Box:	City:	State:	ZIP Code:

If the patient (child) is over age 19 and a full-time student provide the name and address of the school they are attending. Proof of full-time student status for the period of medical expenses in the form of a letter from the school or a transcript is required before the claim can be processed.

Name of school:	Address:
City, state and zip:	

I request my insurance benefits be paid directly to the insured employee. I understand that I am financially responsible for any balance to the physician. I also authorize any dentist, physician, insurance company, organization or employer to release any information including full copies of their records to Standard Security Life or its administrator for any medical treatment, services or benefits rendered or payable to me or on my behalf. A Photostat of this authorization shall be as valid as the original. **I hereby certify that the forgoing answers are true and correct, to the best of my knowledge. Whoever in any document required by the title of the employee retirement income security act of 1974 makes any false statement or representation of fact shall be fined not more than $10,000 or imprisoned not more than five years, or both.**

Employee's signature *Date*

Spouse's signature (if the claim is on the spouse both must sign) *Date*

INSTRUCTION FOR FILING YOUR CLAIM

To expedite the handling of your claim, please follow the instructions listed below. Incomplete forms will be returned to you unprocessed. If you have any questions concerning your benefits or your claims, please call 800-822-3906.

1. *Each covered person must summit a completed form.*
2. *Original bills should be submitted.*
3. *Obtain an itemized bill for each claimant showing: dates of treatment, description of services, specific charges, and the nature of the illness or injury.*
4. *Mail your completed claim form and itemized bills to:* ***Standard Security Life Medical Claims***

C/O Insurers Administrative Corporation

PO Box 21156, Eagan, MN 55121

NOTICE CONCERNING YOUR RIGHTS OF PRIVACY AS A CONSUMER

Standard Security Life and Insurers Administrative Corporation collects nonpublic information about you from the following sources:

- **Information we receive from you in application and other forms;**
- **Information about your transactions with us, our affiliates or others; and**
- **Information we receive from a consumer reporting agency.**

We do not disclose any nonpublic information about our customers or former customers to anyone, except as permitted by law.

We restrict access to your nonpublic personal information to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.