

Employer		Group No.		Employee Name	
Employee Birthdate		Employee Social Security No.		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Employer Name or Group No.				Work Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	
Home Address		(Apt No.)	(City)	(State)	(Zip)
Home Phone No.		Employee Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated			
Name of Spouse		Spouse Birthdate		Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes" (Name, Address and Phone No. of Spouse's Employer)					
Address		(Apt No.)	(City)	(State)	(Zip)
Phone No.					
Patient Name		Date Covered		Relationship to Employee	
If Patient is a Child, are they Married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient Birthdate		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
If Patient is a Child Over Age 19, Provide Name and Address of the School they Attend					
School Name					
Address		(City)	(State)	(Zip)	
Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Semester Enrolled		No. of Semester Hours	
Description of Injury or Illness			Date of Accident or Beginning of Illness		
If Accident, Where and How it Occurred					
Is There Any Other Party Who is or May Be Responsible for Causing or Contributing to the Patient's Illness or Injury? If So, Provide the Name and Address of the Responsible Party, their Insurance Company and Their Attorney					
Responsible Party Name					
Address		(Apt No.)	(City)	(State)	(Zip)
Responsible Party Insurance Company			Responsible Party Attorney		
Was Illness or Injury Due in Any Way to the Patient's Occupation?		If Yes, Please Explain			
<input type="checkbox"/> Yes <input type="checkbox"/> No					
What dates did the patient become disabled or unable to work?		Date Patient Returned From Work			
From _____ Through _____		<input type="checkbox"/> Part Time <input type="checkbox"/> Full Time			
List the Name(s) and Address(es) of All Physicians Who Have Consulted or Treated the Patient For This or Any Similar Condition					
Physician Name		Date First Consulted			
Address		(City)	(State)	(Zip)	
Physician Name		Date First Consulted			
Address		(City)	(State)	(Zip)	
Physician Name		Date First Consulted			
Address		(City)	(State)	(Zip)	
Are You or Any Other Family Member Covered by Another Group Health or Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Health <input type="checkbox"/> Dental					
If Yes, is Coverage Provided through an Employer Sponsored Health or Dental Maintenance Organization (HMO/DMO) Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					



CLAIM FOR HEALTH CARE BENEFITS

4401 82nd Street, Suite 1200 • Lubbock, TX 79424 • Phone: 800-747-9446 • Fax: 806-783-9991 • Customer Service Email: cs@90degreebenefits.com

Name of Other Carrier			
Address of Other Carrier		(City)	(State) (Zip)
Effective Date of Other Coverage	Type of Coverage	<input type="checkbox"/> Self	<input type="checkbox"/> Two-Person <input type="checkbox"/> Family
Employer Name	Group Number		
Employer Address		(City)	(State) (Zip)
Employee/Subscriber Name	Birthdate	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent			
If Eligible, Is Person Enrolled In		If Yes, Effective Date of Part A Is	
Federal Medicare Part A	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Federal Medicare Part B	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Effective Date of Part B Is	

Health care plan fraud is a felony that can be prosecuted. Any employee who willfully and knowingly engages in an activity intended to defraud the company health care plan will face disciplinary action and possible prosecution. I agree that if 90 Degree Benefits, on behalf of the plan, erroneously pays any claims in good faith based on inaccurate or incomplete information provided in my group enrollment materials, claims form(s) or otherwise by myself, my spouse or dependents, I will reimburse the plan in full for any such payment of expenses, including any legal expenses incurred in the recovery of such erroneously paid claims. I hereby certify that the above information is correct. I hereby authorize any physician, hospital, pharmacy, insurance company, employer or other person or organization possessing medical information or information concerning employment of me or any dependent including my spouse (if applicable) to permit 90 Degree Benefits or its representative, including Equifax Services, to view, copy, be furnished copies and be given details of all such medical information. This authorization shall be your authority to release and to furnish 90 Degree Benefits or its representative, including Equifax Services, such information as they may request concerning compensation, job duties, hours spent per week at my employer's place of business or other insurance and information relevant to my lifestyle and habits. I agree that should I or any covered dependent sustain an injury or illness alleged to have resulted from the actions of a third party, that unless otherwise stipulated by the plan, I will repay to the plan out of any monetary recovery all amounts paid by the plan in connection with that injury or illness.

Signature of Employee

Date