CLAIM FOR HEALTH CARE BENEFITS

P.O. Box 21548 • Eagan, MN 55121 • Phone: 888-803-0081 • Fax: 806-698-5858 • Customer Service Email: TSHBPClaims.T8@90degreebenefits.com

Employer	Group No.	Employee Name	
Employee Birthdate	Employee Social Security No.	Gender ☐ Male ☐ Female	Work Status ☐ Active ☐ Retired ☐ COBRA
Employer Name or Group No.			
Home Address (Apt No.) (City) (State) (Zip)			
Home Phone No.	Employee Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Legally Separated		
Name of Spouse	Spouse Birthdate	Is Spouse Employed? ☐ Yes ☐ 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 ☐ Self ☐ Spouse ☐ Child	
If Patient is a Child, are they Married? ☐ Yes ☐ No	Patient Birthdate		
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? ☐ Yes ☐ 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? ☐ Yes ☐ No	If Yes, Please Explain		
What dates did the patient become disabled or unable to work? From Through	Date Patient Returned From Work ☐ Part Time ☐ 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? ☐ Yes ☐ No ☐ Health ☐ Dental			
If Yes, is Coverage Provided through an Employer Sponsored Health or Dental Maintenance Organization (HMO/DMO) Plan? ☐ Yes ☐ No			

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