



**Military Benefit Association Claim Form**  
**Supplemental Group Health Benefits**  
**Policy Number GP01**



Government Personnel Mutual Life Insurance Co.  
 2211 N.E. Loop 410, San Antonio, TX 78217  
 P.O. Box 659567, San Antonio, TX 78265-9567  
 (210) 357-2222 Fax (210) 357-2225  
 www.gpmlife.com

**THE FURNISHING OF THIS CLAIMANT'S STATEMENT SHOULD NOT BE CONSTRUED AS ANY ADMISSION OF LIABILITY ON THE PART OF MBA OR GPM LIFE.**

**INSTRUCTIONS FOR COMPLETION**

- (1) Sections I, II and III must be completed in full by the Member (Insured).
- (2) Section IV must be completed by physician if an itemized bill is not available.
- (3) If you have Champus, Tricare or Medicare, submit explanation of Benefits along with itemized bills.
- (4) If your plan provides coverage for excess charges above Champus/Tricare allowable, submit proof of payment or financial responsibility (excess charges cannot be reimbursed without this information).
- (5) Return completed form to GPM Life insurance Company c/o BeniComp, Inc. 8310 Clinton Park Drive, Fort Wayne Indiana 46825

**SECTION I TO BE COMPLETED BY MEMBER**

Name of Member*		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Military Sponsor's Social Security No.
*Please include other names by which known, such as maiden name, hyphenated name, nickname, derivatave form of first and/or middle name or an alias:				
Name of Patient		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Spouse's Social Security No.
Work Phone Number ( )			Home Phone Number ( )	
Is Patient: <input type="checkbox"/> Yourself <input type="checkbox"/> Your Spouse (Check One) <input type="checkbox"/> Your Child <input type="checkbox"/> Other Explain:		Is Patient: <input type="checkbox"/> Single <input type="checkbox"/> Married (Check One) <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated		Military Status: Active <input type="checkbox"/> Retired <input type="checkbox"/>
If charges due to an accident, please give date of accident and how and where it happened.			Nature of accident or illness. Please describe.	
Please give name and address of any physicians who were consulted for this condition.				
Name		Address		
Name		Address		
Name		Address		
Is patient eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has patient ever been hospitalized for this illness or similar condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", show dates and hospitals:			
Has a claim for benefits for this illness or similar condition been filed previously? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please check the appropriate Government Plan that you are currently insured under (the primary plan that pays before benefits can be paid under this plan):				
Champus Standard <input type="checkbox"/>		Tricare Standard <input type="checkbox"/>		Other _____
Tricare Prime <input type="checkbox"/>		Medicare <input type="checkbox"/>		

I AUTHORIZE any physician, or other medical professional, hospital, clinic, other medical or medically-related facility, insurer or reinsurer, consumer reporting agency or other insurance support organization, pharmacy, governmental agency, group policyholder, employer, or benefit plan administrator having information or records available as to other insurance coverage or the medical care, advice, treatment, or supplies furnished with respect to any physical or mental condition, including information relating to the use of drugs or alcohol, of the patient, employee, or deceased person described below to furnish such information or records to Government Personnel Mutual Life Insurance Company (GPM Life), its reinsurers and agents, or an attorney, benefit plan administrator, preferred provider organization, utilization review firm, medical case manager, or insurance support organization acting on GPM Life's behalf. I also authorize any employer, group policyholder, or benefit plan administrator to give to GPM Life any of the previously-described parties acting on GPM Life's behalf any employment-related information available to them.

I UNDERSTAND the information obtained by use of this authorization will be used by GPM Life, its legal representatives, and any person or organization administering claims on behalf of GPM Life to determine eligibility for group insurance benefits.

I AUTHORIZE GPM Life, its legal representative, and any person or organization administering claims on behalf of GPM Life to release to GPM Life's group policyholder a summary of claims incurred by me or my insured dependents, for the purpose of verifying the claims submitted under my group health insurance plan or for the purpose of conducting an audit of GPM Life's operations or services. This summary of claims will be provided in aggregate and disclosed in a format that will not identify the person by name with his/her condition.

This authorization shall be valid for the duration of this claim. I further agree that a photocopy of this authorization shall be as valid as the original.

I UNDERSTAND that I have a right to receive a copy of this authorization upon request.

WE CERTIFY THAT THE FOREGOING STATEMENTS AND ANSWERS ARE TRUE AND COMPLETE TO THE BEST OF OUR KNOWLEDGE AND BELIEF.

Date	Signature of Member	Signature of Spouse
Mailing Address	Street	City State Zip Code

**SECTION II PATIENT & SUBSCRIBER INFORMATION**

1. PATIENT OR AUTHORIZED PERSON'S SIGNATURE I Authorize the release of any medical information necessary to process this claim.		2. I Authorize payment of medical benefits to undersigned physician or Supplier for service described on back page.	
Signed	Date	Signed (Covered or Authorized Person)	Date

**SECTION III - Type or Print PATIENT & SUBSCRIBER INFORMATION**

1. PATIENT'S NAME (First Name, Middle Initial, Last Name)

# Supplemental Health Plan Claim Form

SECTION IV		ATTENDING PHYSICIAN'S STATEMENT			
1. Date of Illness (First symptoms) or Injury (Accident) or Pregnancy (LMP):		2. Date first consulted you for this condition:		3. Has patient ever had same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Date patient able to return to work:		5. Dates of total Disability: From _____ Through _____		6. Is Patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Name of Referring Physician:			8. For services related to hospitalization, give hospitalization dates: Admitted _____ Discharged _____		
9. Name & address of facility where services rendered (if other than home or office):			10. Was laboratory work performed outside your office? <input type="checkbox"/> Yes <input type="checkbox"/> No		
11. Diagnosis or Nature of Illness or Injury: 1 _____ 2 _____ 3 _____			12. WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			13. HAVE YOU CERTIFIED A HOME HEALTH CARE TREATMENT PLAN FOR THIS PATIENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Relate Diagnosis to Procedure in Column D by Reference to Numbers 1,2,3 or DX Code					
14. A	B*	C Fully Describe Procedures, Medical Services or Supplies Furnished for Each Date Given: Procedure Code (Identify) (Explain unusual services or circumstances)	D	E	F
Date of Service	Place of Service		Diagnosis Code	Charges	
15. Signature of Physician or Supplier		16. Accept Assignment Champus or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. Total Charge	
Signed _____		20. Your Social Security No. **		18. Amount Paid	
Date _____		23. Your Employer I.D. No. **		19. Balance Due	
22. Your Patient's Account No.		21. Physician's or supplier's Name, Address, Zip Code, Telephone No. and I.D. No.**			

**\* PLACE OF SERVICE CODES**

- 1 - (IH) - Inpatient Hospital
- 2 - (OH) - Outpatient Hospital
- 3 - (O) - Doctor's Office

**\*\* PAYMENT WILL BE MADE TO COVERED PERSON IF NO I.D. NUMBER IS PROVIDED.**

- 4 - (H) - Patient's Home
- 7 - (NH) - Nursing Home
- O - (OL) - Other Locations
- 5 - Day Care Facility (Psy)
- 8 - (SNF) - Skilled Nursing Home
- A - (IL) - Independent Laboratory
- 6 - Night Care Facility (Psy)
- 9 - Ambulance
- B - Other Medical Surgical Facility

**ARIZONA** — For your protection ARIZONA LAW, ARS 20-466.03, REQUIRES THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**ARKANSAS** — THIS STATEMENT IS REQUIRED BY ARKANSAS INSURANCE CODE SEC. 23-65-503: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**CALIFORNIA** — FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: Any person who knowingly presents false or fraudulent claims for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**COLORADO** — WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**DISTRICT OF COLUMBIA** — WARNING: - It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FLORIDA** — WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**KENTUCKY** — FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**MARYLAND** — WARNING: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NEW JERSEY** — WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**NEW MEXICO** — THIS STATEMENT IS REQUIRED BY NEW MEXICO LAW HB141.08. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**OHIO** — FRAUD WARNING: Any person who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application

or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**OREGON** — WARNING: Any person who, with intent to defraud or knowing that she/he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

**PENNSYLVANIA** — WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**TENNESSEE** — FRAUD WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**VIRGINIA** - FRAUD WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may have violated state law.

**WASHINGTON** - WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**ALL OTHER STATES** — FRAUD WARNING: Any person who, with intent to defraud or knowing that she/he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.