EMPLOYEE BENEFIT
SERVICES, INC.

Employee Benefit Services, Inc.
PO Box 1929
Fort Mill, SC 29716-1929
Phone 800-242-1510
FAX 803-396-1800

Employer: ______________________

Employee's Name: ______________________ Social Sec. No. ☐☐☐-☐☐-☐☐☐☐

Current Address: ______________________
Street City State Zip

☐ Check if this is a new address

Patient's Name: __________ Relationship: __________ Date of Birth: __________

If claim is for a dependent child age 19 or older, is dependent a full-time student?

☐ Yes ☐ No If Yes, where? ______________________

Is this claim due to an accident? ☐ Yes ☐ No If Yes, please explain: ______________________

______________________ Date of Accident: __________

Was this a motor vehicle accident? ☐ Yes ☐ No If Yes, explain (Insurance information, Lawyer, etc.): __________

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Is this accident work related? ☐ Yes ☐ No

Is your spouse employed? ☐ Yes ☐ No If Yes, where? ______________________

Are you or your dependents entitled to benefits under any other employer, student association, group plan, HMO, Medicare, Medicaid, etc? ☐ Yes ☐ No Name of other group plan: __________ Group No. __________

To avoid delays in processing the attached medical claims, please enclose itemized statements which include date of service, type of service, amount, diagnosis and patient's name.

Do you want benefits paid directly to the provider(s)? ☐ Yes ☐ No

Employee's Signature: ______________________ Date: __________

Signature Also Required Below

IMPORTANT NOTICE

FRAUD STATEMENTS ARE REQUIRED BY SOME STATES

Florida: "Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree."

New Jersey: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

All other states: "Any person who knowingly and with intent to defraud any insurance company or other person files a 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."

SIGN HERE	I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacist to release any information requested with respect to this claim and the attached bills. I certify that the information furnished by me in support of this claim is true and correct. A photostatic copy of this authorization shall be considered as effective and valid as the original. Signed (*Insured Employee*): ______________________ Also Dependent (*If patient is not a minor*): ______________________ Date: ______________________