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GROUP HEALTH CLAIM FORM

(For Medical and Vision Claims)

Claim Filing Process:

1. The employee completes the sections below.
 2. The employee mails the completed form to the address shown at left.
- NOTE:** Failure to answer all questions may delay payment.

Employee Completes

Employer's Name:	Group Number (refer to ASR ID card):
Employee's Name:	Date of Birth:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated	
Address:	
Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, date last worked:
Spouse's Name:	Spouse's Date of Birth:
Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is spouse eligible for insurance through employer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name, Address, and Phone Number of Spouse's Employer:	
Patient's Name:	Patient's Date of Birth:
If patient is a dependent child, please answer the following:	If the dependent child is age 19 or older, please complete the following:
Is the child in employee's custody? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of College: _____
Is the child financially dependent on employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	Enrollment Date: _____
Are you eligible for a tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No	Graduation Date: _____
Claim is for which of the following? <input type="checkbox"/> Accidental Injury <input type="checkbox"/> Illness <input type="checkbox"/> Annual/Routine Health Exam	
Date Illness Began:	Date of First Treatment:
Nature of illness for which you are being treated:	
Is claim for an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date of accident:
Where did it occur?	Is the accident work related? <input type="checkbox"/> Yes <input type="checkbox"/> No
How did it occur?	
Are you or your dependents covered under another group insurance plan, HMO, or a governmental plan such as Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, group name:	Name of member insured under other plan:
Policy Number:	Status of Member: <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA Participant
Effective date of other policy:	Termination date of other policy:
Name and address of other insurance company:	

PAYMENTS AND REIMBURSEMENT

I understand that all medical benefits will be issued directly to the service provider unless written evidence/receipt is submitted to ASR showing that I paid the charges. I realize that I am financially responsible for the charges my Plan/Policy does not pay. I agree to reimburse the Plan/Policy for any overpayments in excess of what the Plan/Policy allows. I agree to advise the Plan/Policy of any claim against a third party to recover any damages arising out of the event causing the Plan's/Policy's payment of benefits as soon as I am aware that I may recover damages from another party. If I fail to provide the Plan/Policy with written notice of a claim or compromise or settle a claim without prior written consent, the Plan/Policy shall deem that I have committed fraud or misrepresentation in a claim for benefits and shall have the right to terminate my participation in the Plan/Policy. I further agree to reimburse the Plan/Policy for all benefits paid to me or on my behalf if I recover any money for the same accident or illness for which benefits were paid. This agreement applies to all recoveries, including benefits paid or recovered under any state or federal worker's compensation statute, whether by redemption, voluntary payment, compromise, settlement, court order, or any other form.

CERTIFICATION

I certify that these statements and answers are true to the best of my knowledge and belief.

Date: _____ Employee's Signature – **DO NOT TYPE OR PRINT:** _____