

q3 business technology corp.
P. O. Box 15952
Fort Wayne, IN 46885

www.q3online.com
Phone 260.492.9979 877.251.8324
Fax 260.492.9989

Group Benefit Plan Claim Form

Note: Every item must be completed before claim can be processed! (please print in ink or type)

As shown on ID card, Plan Name: _____ ID #: _____

As shown on ID card, Enrollee Name: _____ ID #: _____

Claimant Name: _____ Soc Sec #: _____ Date of Birth: _____

Claimant Relationship to Enrollee: Self Spouse Child

Is the claimant employed? Yes No If an adult child, a full-time student? Yes No

Name of school or employer: _____ Address: _____

City, State, Zip Code: _____ Telephone #: _____

Enrolled through: _____(date) Currently carrying: _____ Quarter hours Semester hours
Please attach documentation from the school showing proof of enrollment

Is this claim a result of: Illness Pregnancy Injury
Date of First Symptom: _____
Expected Delivery Date: _____
Date of Accident: _____

Please provide details: _____

Is any other insurance involved? Yes (complete Other Coverage information below) No

Is this claim in any way occupational in nature? Yes No

Is this claim covered by Worker's Compensation? Yes No

Do any family members have coverage under any other Group or Insurance Plan (including employer provided coverage, private insurance, student insurance, COBRA, Medicare and Medicaid)? Yes (complete Other Coverage information below) No

Other Coverage (if applicable)

Plan Name: _____ Plan #: _____

Plan Address: _____

Plan City, State, Zip Code: _____

Policy # or Enrollee ID #: _____ Plan Telephone #: _____

Family member(s) covered under Plan: _____

If there is more than one plan providing other coverage, provide additional information on the back of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health or that of my family listed on this form to give to my employer or its insurers any such information. A photographic copy of this authorization shall be as valid as the original. I hereby certify that the above answers are true and complete to the best of my knowledge and are the basis under which benefits are provided under this Plan. I have read and agree to abide by the Subrogation and Reimbursement provisions of this Plan contained in the Summary Plan Description.

Signature of Claimant (if an adult)

Date

Signature of Enrollee

Date