Horace Mann
Founded by Educators for Educators

MED/GRBENCLMS

Group medical claim form

Instructions are on page 3.

Employee — Complete this section

Date last actively at work

Insured's status ☐ Active ☐ Retired ☐ Medical continuance

Employer's name, address

Policy number

Employee's name (first, middle initial, last)

Sex ☐ F ☐ M

Date of birth

Employee's address (street, city, state, zip)

Employee's Soc. Sec. number

Employee's phone number
Home ( ) Bus. ( )

Marital status:
☐ Married ☐ Single ☐ Divorced ☐ Separated

Spouse's name | Spouse's date of birth | Spouse's Soc. Sec. Number

Patient's name | Date of birth | Relationship | Patient's Soc. Sec. #

If child, is she/he married? ☐ Yes ☐ No

Is child a full-time student? ☐ Yes ☐ No

If yes, attach verification from registrar's office. This is due in January and September of each year.

Description of accident or illness

Happened at 1. ☐ Home 2. ☐ Work 3. ☐ Other

Accident or illness due to employment? ☐ Yes ☐ No

Date of accident or beginning of illness

Have you or your dependent, or will you or your dependent file claim for Worker's Compensation benefits? ☐ Yes ☐ No

Are you or your dependent covered under another group medical insurance plan, HMO plan or government plan such as Medicare which will also cover any of the medical expenses of this claim? ☐ Yes ☐ No
If yes, give name of insurance company, organization, or HMO providing benefits.

Name and address

Policy Number

Name and address of insured

Patient's Medicare eligibility
Part A ☐ Yes ☐ No If yes, please give effective date. Mo ________ Date ________ Year ________
Part B ☐ Yes ☐ No If yes, please give effective date. Mo ________ Date ________ Year ________

Authorization to release information — I hereby authorize any provider, insurance company, Blue Cross - Blue Shield plan, employer or organization to release any information regarding my (or my dependent's) insurance coverage or medical history, including disability or employment related information concerning this claim to Horace Mann Life Insurance Company for the purpose of validating and determining benefits payable in connection with this claim.

Patient's signature (parent or guardian if claim is on a minor) | Date

Payment authorization — I authorize payment of all medical benefits for services rendered from those physicians or providers described on page 2 and/or as indicated on the enclosed bills.
If yes, employee's signature | Date

I certify that the foregoing information is true and correct.
Employee's signature | Date

Physician or provider complete this section

Diagnosis or nature of illness or injury - Relate diagnosis to procedure in Column D by reference to numbers 1, 2, 3, etc. or ICD-9 code.

1.

2.

3.

4.

Date first consulted for this condition	Hospital confinement dates From To	Date total disability began	Date able to return to work

Name and address of referring physician

A. Date of service	B. Place of service*	C. Fully describe procedures/medical services/supplies furnished for each date given (explain unusual services or circumstances). Procedure code (Identify:)		D. ICD-9 diagnosis code	E. Charges	

Your patient's account #	Physician's or provider's tax identification number or social security number. Tax I.D. #	Total charge		
		Amount paid		
	Soc. Sec. #	Balance due		

Physician's or provider's name and address	Physician's or provider's telephone # ( )

I certify that the foregoing information is true and correct and that the charges are the actual charges to the insured.	Physician's or provider's signature	Date

* 1. (IH) - Inpatient hospital
2. (OH) - Outpatient hospital
3. (O) - Doctor's office
4. (H) - Patient's home
5. (PSY) - Day care facility
6. (PSY) - Night care facility
7. (NH) - Nursing home
8. (SNF) - Skilled nursing facility
9. Ambulance - home
O. (OL) - Other locations
A. (IL) - Independent laboratory
B. Other medical facility

State mandated notices

For your protection, state law requires the following to appear on this form.

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.

Alabama – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska – A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing a false, incomplete, or misleading information may be prosecuted under state law.

Arizona – Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California – Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado – 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.

Connecticut, Oregon and Vermont – Any person who knowingly and with intent to defraud an insurer submits an application or files a claim containing false, incomplete, or misleading statements of material fact may be guilty of a crime.

Delaware, Idaho, Indiana – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida – 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.

Georgia, Kansas, Nebraska, Texas – 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 may be guilty of a crime and may be subject to fines and confinement in prison.

Illinois – If we do not pay this claim within 31 days from the date of receipt of due proof of loss, we will pay interest at the rate of 10% annually, from the date of the insured's death, on the total amount payable or the face amount if payments are to be made in installments until the total amount or first installment is paid.

If you have any concerns about this claim, you may take the matter up with the Illinois Department of Insurance, which has a Consumer Division in Chicago at 100 W. Randolph Street, Chicago, IL 60601, and in Springfield at 320 West Washington Street, Springfield, IL 62767.

Kentucky – 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

Maine and Tennessee – 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.

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

Minnesota and Washington – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

New Hampshire – Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Pennsylvania – 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.

Instructions for filing a claim

1. Complete employee information section

Use a separate claim form for **each** member of the family for each separate accident or illness. If claim is for a dependent child, age 19 or over, and who is a full-time student, be sure to include written verification from the registrar's office of the school to establish eligibility.

Important — To ensure proper identification, be certain your social security number, your policy number, spouse's social security number and patient's social security number appear on the claim form. Also complete all other blocks applicable to the current claim as failure to include all information may delay processing of your benefits.

If you wish your benefits paid directly to the physician or provider of service, sign and date the box titled Payment authorization.

Please keep **copies** of bills submitted - bills will not be returned to you.

Photostatic copies of bills and cancelled checks are not acceptable.

2. Attending physician or provider information should be completed . . . .

For surgery

For hospital confinement

For doctor's visits

For any other medical treatment

Be certain to include procedure code and ICD-9 diagnosis code (physician or provider section, blocks C and D).

3. Completed claim form and itemized bills should be submitted to Horace Mann Life Insurance Company, P.O. Box 20487, Springfield, IL 62708-0487.

Itemized bills should include:
Employee name
Patient name
Type of service
Physician name
Diagnosis
Charge for service
Important — Be certain to include tax identification number for Physician or provider

Drug bills should include:
Patient name
Physician name
Prescription number
Prescription date
Charge

Save Explanation of Benefits form provided to you — additional photostatic copies are not available.