## CLAIM REIMBURSEMENT FORM



Please complete the form below and attach all bills pertaining to this specific claim only. Use a separate claim form for each dependent. Send this form and all attachments through one of the methods listed below:

*If sending by mail, mail to:*Assured Benefits Administrators
P.O. Box 211517

Eagan, MN 55121-2717

If sending by facsimile, fax to: 915-532-0159

If you have any questions, contact us at 1-800-247-7114. Our customer service representatives are available Monday through Friday from 8 a.m. to 6 p.m. Central Standard Time.

EMPLOYEE NAME	EMPLOYER
SSN PHONE	EMAIL
ADDRESS	STATE ZIP
CLAIM IS FOR: EMPLOYEE SPOUSE CHILD CLAIMANT'S DATE OF BIRTH	
IF THIS CLAIM IS FOR A CHILD OVER 19 YEARS OF AGE, IS THE CHILD A FULL-TIME STUDENT? YES NO	
If YES, SCHOOL NAME	
DOES THE CLAIMANT HAVE OTHER HEALTH INSURANCE COVERAGE? YES NO	
If YES, OTHER INSURANCE CARRIER	ELIGIBILITY DATES
REASON CLAIM IS BEING FILED: ACCIDENT MATERNITY NEWBORN WELL PATIENT DENTAL VISION  If ILLNESS, DATE SYMPTOMS FIRST APPEARED DATE PHYSICIAN FIRST CONSULTED	
DATE FITSICIAN FIRST CONSULTED	
If ACCIDENT, GIVE DETAILS	
I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER OF THESE SERVICES. YES NO	
	PRINT NAME
SIGNATURE	DATE

REMINDER: PLEASE ATTACH ALL RECEIPTS.