STATEMENT OF HEALTH

EMPLOYEE BENEFIT SERVICES

CLAIM NUMBER

_____ – _____ – _____ – _____ – _____

TO BE COMPLETED BY **MEMBER**

INSURED EMPLOYEE'S NAME	INSURED EMPLOYEE'S IDENTIFICATION NUMBER

INSURED EMPLOYEE'S STREET ADDRESS	CITY	STATE	ZIP CODE

NAME OF EMPLOYER (GROUP POLICYHOLDER)	GROUP POLICY NUMBER

TO BE COMPLETED BY **PHYSICIAN**

NAME OF DEPENDENT	SEX	DATE OF BIRTH	NATURE OF DISABILITY	DATES OF TOTAL DISABILITY
				FROM:
				TO:
				FROM:
				TO:
				FROM:
				TO:
				FROM:
				TO:
				FROM:
				TO:
				FROM:
				TO:
				FROM:
				TO:

PHYSICIAN'S NAME	PHYSICIAN'S TELEPHONE NUMBER

PHYSICIAN'S STREET ADDRESS	CITY	STATE	ZIP CODE

PHYSICIAN'S IDENTIFICATION NUMBER	PHYSICIAN'S EMPLOYER I.D. NUMBER	SIGNATURE OF PHYSICIAN
		X

MEMBER SIGNATURE

I hereby authorize my insurance company, prepayment organization, employer, hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or service. I certify that the information by me is support of this claim is true and correct. A copy of this authorization shall be valid.

X _____ _____

SIGNATURE OF INSURED PERSON DATE

Please return to: Attn: _____

Employee Benefit Services / P.O. Box 82669 / Lincoln, NE 68501-2669 or fax to **402-467-7336**