

RURAL CARRIER BENEFIT PLAN

P.O. Box 668329, Charlotte, NC 28266-8329

FORM FOR CLAIMING BENEFITS

✓ CHECK HERE IF
NEW ADDRESS
SINCE LAST
SUBMISSION.
DATE RELOCATED
//___

IMPORTANT: This side of the claim form must be fully completed by the insured and submitted to the Plan before any benefits can be paid.

WARNING: Any intentional false statement in this claim of willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000, imprisonment of not more than five years, or both. (18 U.S.C. 1001)

Name of Member _____ Sex _____ Circle Your Enrollment Code 381
LAST FIRST MIDDLE Number 382

Mailing Address _____ Identification No. _____
(Please copy from I.D. Card)

City _____ State _____ Zip Code _____ Date of Birth _____

TO BE COMPLETED BY INSURED MEMBER

Claim is made for Self Dependent _____ Relationship to insured _____ Date of Birth _____ Sex: Male Female
Dependent's marital status: (Check One) Single Married

Describe Sickness/Accident Suffered _____

If accident: (a) Date of accident _____ (b) How and where did accident occur _____
(Month) (Day) (Year) (Hour)

Was accident or sickness work related? Yes No If "Yes", report must be made and expenses submitted to: D.O.L. Office of Workers Compensation or other Worker's Compensation Plan.
First day unable to work _____ Date returned to work _____
Date Date

DOUBLE COVERAGE AND MEDICARE INFORMATION

(See "Limitations" section of your brochure)

IMPORTANT: This question must be answered before claim can be processed.

(a) Are you or any member of your family covered under any health plan other than Rural Carrier Benefit Plan? Yes _____ No _____

(b) If answer is "Yes" complete the following:

Person in whose name the other plan is issued: _____
Name of Insurance Company or Plan _____
Address of Claims Office _____

Policy or Contract Number _____ is Plan Family _____ or Self only _____ coverage? (Check appropriate block)
(c) Is this other plan issued under a Group _____ or individual _____ contract? (Check appropriate block)

IMPORTANT: This question must be fully answered by persons age 65 or older and persons under age 65 receiving disability benefits through Social Security.

Medicare coverage (see your official brochure) (a) Are you or any member of your family covered under Medicare? Yes No
(b) If "Yes" indicate name of person and check the type of coverage.

SELF: _____ Hospital (Part A) Medicare (Part B) Effective Date _____
SPOUSE: _____ Hospital (Part A) Medicare (Part B) Effective Date _____
DEPENDENT: _____ Hospital (Part A) Medicare (Part B) Effective Date _____

(c) If you or your spouse are 65 or over, indicate whether you are actively employed.

Self: Yes No Employer _____
Spouse: Yes No Employer _____

Authorization for direct payment of benefits.	I authorize payment directly to _____ of the Medical and/or Surgical Benefits otherwise payable to me. (Print name of physician) Date _____, 20____ Signed _____ (Signature of member)
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Any physician or any hospital, including any federally assisted alcoholism or drug program, may disclose medical information regarding _____ claim for benefits to Mutual of Omaha Insurance Company and/or the Rural Carrier Benefit Plan. This information will be used to evaluate the claim for benefits. This consent is subject to revocation at any time except to the extent that the provider which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will be valid for the duration of the claim. A photocopy of this authorization shall be as valid as original.

Signature of Patient _____ Date _____

Signature of parent/guardian _____ Date _____
(If patient is a minor or incompetent)

FOLLOW INSTRUCTIONS IN YOUR BROCHURE ON "HOW TO CLAIM BENEFITS"

HAVE YOU ANSWERED EVERY QUESTION?

HAVE YOU DATED AND SIGNED THIS FORM?

