

SAG-AFTRA HEALTH PLAN

3601 W. Olive Ave., Burbank, CA 91505 • Mailing Address: P.O. Box 7830, Burbank, CA 91510-7830
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Medical Claim Form

Instructions for filing a claim:

If you have other insurance as your primary coverage, submit your bills to your other health insurance carrier first. When you receive its Explanation of Benefits (EOB), attach a copy of it — along with an itemized bill — to this claim form and follow instructions 1 through 3 below for filing a claim with the SAG-AFTRA Health Plan (Plan).

1. **Complete this form** (required for each family member).
2. **Sign and date the form.** The participant must sign and date this form. In addition, the spouse's signature is required if the claim is for a spouse.
3. **Mail the form** to the mailing address indicated above.

Participant information

Name:		Participant health care ID (HCID):		
Address:				
City:		State:	Zip:	New address? <input type="checkbox"/> Yes <input type="checkbox"/> No
Home phone: () -		Work phone () -		
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Legally separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed

Patient information

Name:		Birthdate: / /		
Does the patient have his/her own SAG-AFTRA Plan coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is patient covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to participant:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
Do you or other family members have medical health insurance other than the Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Other health insurance coverage? Yes No If yes, complete below:

Name of insured:				
Relationship:		Insurance ID #:		
Name of other insurance:				
Address:				
City:		State:	Zip:	Phone: () -

Is this claim due to an accident? Yes No If yes, complete below:

Date of accident/injury: / /			Location:	
How did it occur?				

Was illness or injury caused by the patient's job? Yes No If yes, complete below:

Date of accident/injury: / /			Time:	
Employer:				
Have you/your dependent filed a claim for workers' compensation benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, medical practitioners, hospitals, pharmacies, or other institutions rendering care and treatment to furnish the SAG-AFTRA Health Plan with full information regarding the care and treatment rendered (including copies of their records).

Participant signature

Spouse signature (required if claim is for spouse)

Date

Any person who knowingly and with intent to injure, defraud, or deceive files a statement of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law. Please be advised that no rights under the Plan, including but not limited to the right to receive any benefit or any right to pursue a Claim or cause of action, are assignable to another party. For more information see the "Authorized Representatives" section on page 102 of the SPD.