

# Claim Identification Form

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**We can't process claims we can't identify.** To help us identify your claim faster, you must complete this Claim Identification Form. Please follow the instructions below.

1. Complete This Claim Identification Form (Claim ID Forms may be photocopied).
2. Attach original bills (bills may NOT be photocopied).
3. Attach copy of "Certificate of Creditable Coverage" from your prior insurer with your 1st claim.
4. Mail to the address below. (Facsimile documents CANNOT be accepted.)

**Please submit your claim within 90 days of the date of service.**

Connecticut General Life Insurance Company  
P. O. Box 55270  
Phoenix, AZ 85078-5270  
**(877) 209-7098**

Employee Name		Social Security Number
Home Address		Employee Birth Date
City & State	Zip	Telephone No.
Name of Employer		Has Employment Terminated? Yes <input type="checkbox"/> No <input type="checkbox"/>
City & State		If Yes, Date
Patient Name (if other than Employee )		Male <input type="checkbox"/> Female <input type="checkbox"/>
Patient Relationship to Employee	Patient Birth Date	Is Patient Married? Yes <input type="checkbox"/> No <input type="checkbox"/>
Nature of Sickness, Injury, Diagnosis or Medical Visit		

Underwritten by Connecticut General Life Insurance Company.

This authorization is valid for the term of the policy or contract under which a claim has been submitted.

Signed (Employee, All Claims) X \_\_\_\_\_ Date \_\_\_\_\_

Patient or Parent (if minor) X \_\_\_\_\_ Date \_\_\_\_\_

Any person who knowingly (with intent to injure, defraud, or deceive the insurance company) files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and maybe subject to fines and confinement in prison.

I certify that each of the statements made as part of this claim are complete and true to the best of my knowledge and belief.

Employee Signature \_\_\_\_\_