

Connecticut General

P.O. Box 55270
Phoenix, AZ 85078

Forwarding Service Requested

Customer Service:

Date:
Employee:
Employer:
Group No:
Patient:
SSN/Member ID:

We have received a claim for the above patient and require the following information. Please list all dependents covered under the plan.

- 1. Name _____ Relationship _____
DOB _____ Full-Time Student over age 19? Yes ____ No ____
- 2. Name _____ Relationship _____
DOB _____ Full-Time Student over age 19? Yes ____ No ____

If your dependent is actively enrolled as a full-time student in an accredited learning institution (university, college, or technical trade school), please submit a copy of the student's registration indicating the number of credit hours. This information is necessary for each semester (proof of student status does not apply to Texas residents or members of BP Retail).

If you had medical coverage prior to this plan, please attach a 'Certificate of Creditable Coverage' to this letter.

If the patient is NOT a spouse, natural child or adopted child of the insured, we reserve the right to require a current court order or a copy of your most recent Federal Tax Return showing the patient as a dependent. Providing this documentation is not a guarantee of eligibility.

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 _____ Date _____

The policy requires your claim be filed within 90 days of the date of service. All information to process your claim must be received within 1 year unless you were legally incapacitated (legally unable to file the claim). For example, 90 days and 1 year after the date of service.

Claims Department