90 DEGREE BENEFITS
A Turn For The Better

Claim Form

Claims Address:
2810 Premiere Parkway, Ste. 400
Duluth, GA 30097
800-239-3503
Fax: 678-258-8299

EMPLOYER INFORMATION

Employer Name: | Group No.:

Location Name:

EMPLOYEE INFORMATION

Last Name: | First Name: | MI:

Social Security #: | Date of Birth (Mo./Day/Yr.):

Home Address (Street No./Apt. No.):

City, State, Zip Code:

Are You: ☐ Actively Employed ☐ Retired ☐ Disabled ☐ On COBRA***

Are You: ☐ Single ☐ Married ☐ Widowed ☐ Divorced **(**If divorced see Reverse Side)**

*** **If COBRA**: Are you currently employed? ☐ No ☐ Yes Date of last premium payment _____/_____/_____

If yes, please list the name and address of your employer:

Name and address of group coverage plan:

Date you or your dependents will be eligible for coverage:

SPOUSE INFORMATION

Last Name: First Name: Social Security #:

Date of Birth (Mo./Day Yr.): | Is Spouse Employed? ☐ Yes ☐ No

If Yes: Name of Employer: | Telephone No.: ( )

Employer's Address:

1. Is your spouse covered under his/her employer's plan? ☐ No ☐ Yes **IF YES**, answer 2-4
2. Is coverage? ☐ Single ☐ Family
3. Name of Insurance Carrier: _____ Telephone No.: (_____) _____
4. Address: _____

CLAIM INFORMATION (Please attach copy of receipt or physician's statement of services)

Claim is for: ☐ Medical Expense ☐ Dental Expense ☐ Vision Expense

Claim is for: Name: | Relationship: | Date of Birth:

Is Claim related to an ACCIDENT? ☐ No ☐ Yes Date of Accident _____/_____/_____

Please describe how and where accident occurred:

****If claim is for child, please complete back of form****

Statement of Accuracy:

I hereby confirm that all information provided is a complete, accurate and truthful statement pertinent to this claim submission.

Date: _____ 20 _____ Employee's Signature: _____

Assignment of Benefits:

I hereby Authorize Payment of medical/dental/vision benefits available on submitted charges directly to the appropriate Provider of Service.

Date: _____ 20 _____ Employee's Signature: _____

Authorization To Release Information/Acknowledgement:

I hereby authorize any Hospital, Physician, Organization, Employer, Insurance Company or Administrator to release any information requested pertinent to my claims while covered under Covenant Administrators.

Date: _____ 20 _____ Employee's Signature: _____

Or other duly authorized person on behalf of Employee _____

The employee or person authorized to act on behalf of the Employee is entitled to receive a copy of this authorization form.

DEPENDENT INFORMATION

Please complete *all* sections below:

Child's Full Name: Last Name: First Name:

If Divorced and claim is for child, please complete:

Other Natural Parent's Name: Last Name: First Name:

Social Security #: Date of Birth:

This Parent's Place of Employment:

Employer's Address:

Employer's Telephone #:

Relationship to you:

- ☐ Natural Child Lives with you
- ☐ Natural Child Lives with other Natural Parent
- ☐ Step-Child Lives with you
- ☐ Step-Child Does not live with you
- ☐ Other: Please specify relationship

Before any claim can be processed for this child we must have the following:

A. A copy of that portion of your divorce decree that mandates which party is to provide coverage for medical and/or de7ntal care for this dependent.

B. If this issue is ***not*** specified in your divorce decree, you ***must*** provide either

1. A copy of the legal assignment of Medical Care provided by a court ***OR***
2. A notarized statement that you are principally responsible for the medical care of this dependent child.

If you have already submitted this information to us, please advise below the approximate date of submission.

Date Submitted: _____

I certify that the above is a complete statement of other medical care/coverage available for the above dependent.

Signature of Employee: _____ Date: _____ -