

# statement of health

## Employee Benefit Services

CLAIM NUMBER
_____ - _____ - _____ - _____

### to be completed by member

INSURED EMPLOYEE'S NAME		INSURED EMPLOYEE'S IDENTIFICATION NUMBER	
INSURED EMPLOYEE'S STREET ADDRESS		CITY	STATE ZIP CODE
NAME OF EMPLOYER (GROUP POLICYHOLDER)		GROUP POLICY NUMBER	

### to be completed by physician

NAME OF DEPENDENT	SEX	DATE OF BIRTH	NATURE OF DISABILITY	DATES OF TOTAL DISABILITY	
				FROM:	TO:
				FROM:	
				TO:	
				FROM:	
				TO:	
				FROM:	
				TO:	
				FROM:	
				TO:	
PHYSICIAN'S NAME			PHYSICIAN'S TELEPHONE NUMBER		
PHYSICIAN'S STREET ADDRESS		CITY	STATE	ZIP CODE	
PHYSICIAN'S IDENTIFICATION NUMBER	PHYSICIAN'S EMPLOYER I.D. NUMBER	SIGNATURE OF PHYSICIAN			
		<b>X</b>			

### member signature

I hereby authorize my insurance company, prepayment organization, employer, hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or service. I certify that the information by me is support of this claim is true and correct. A copy of this authorization shall be valid.

**X** \_\_\_\_\_ DATE \_\_\_\_\_  
SIGNATURE OF INSURED PERSON

**Please return to:** Attn: \_\_\_\_\_  
Employee Benefit Services  
P.O. Box 82669, Lincoln, NE 68501-2669 or fax to **402.309.2580**