

Notice of Claim



Return this claim form and itemized hospital bill (UB92) to:
 Alta Health & Life Insurance Company
 P.O. Box 2568
 Jacksonville, FL 32203-2568
 Phone: 1-(800) 888-5256

FOR OFFICE USE ONLY	
PLAN	_____
EFF. DATE	____/____/____
PTD	_____
INT	_____

FLORIDA

- 30/20 PLAN 365+ PLAN
 PPP PLAN PRE-TAX SUPP./SIS HEALTH PLAN

HELP SPEED YOUR CLAIM BY

Following these easy steps

1. Complete the "Notice of Claim" claim form.
(Please answer all questions and sign it.)
2. When you have completed the claim form return it to the address shown above along with your ITEMIZED BILLS (UB92).

Please remember . . .

- To be sure to submit a claim form for each separate illness or injury.
- To submit separate claim forms and bills for yourself and each of your dependents who have claims.

Employee's Statement	1. Employee's name _____	Phone No. () _____	Employee Social Security No. _____
	2. Employee's Mailing Address Street _____	City _____	State _____ Zip Code _____
	3. Insured's employment:		
	Department name _____		
	Are your premium payments being made by: 1) Payroll deduction <input type="checkbox"/> 2) Personal check <input type="checkbox"/>		
	Are you a retired employee? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	4. This claim is for:		Dependent Social Security No. _____
	<input type="checkbox"/> Employee <input type="checkbox"/> Child Name _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child Date of birth of employee ____/____/____ Date of birth of patient ____/____/____		
	5. If step-child, does this child reside with you?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	6. If patient is a child or step-child over 19 years old.		
Does this child reside with you?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this child wholly dependent on you for support and maintenance?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this child attend school as a full-time or part-time student?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name and address of school _____			
7. Is this claim being filed under Workers' Compensation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Has insured's name changed since policy was issued?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, give name on date policy was issued _____			
9. Name of hospital _____			
Address _____			
Date of admission ____/____/____		Phone () _____	

The above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, or employer to release information to Alta as is required to properly pay all benefits, if any, due me, my spouse, or parent for this claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date ____/____/____ Signature X _____ X _____
 Signature Patient (or if minor, parent)

Fully complete this form then ATTACH A COPY OF THE HOSPITAL'S ITEMIZED BILL INCLUDING DIAGNOSIS CODE TO THIS FORM and send both to the address shown above.