

STATEMENT OF CLAIM

GEMGroup

COMPLETED FORM TO BE RETURNED TO:

GEMGroup
BRANDYWINE CORPORATE CENTER
SUITE 303
650 NAAMANS RD.
CLAYMONT, DE 19703

TELEPHONE NUMBERS:
302-798-6801
800-223-7405

INSTRUCTIONS: This form is to be used to submit a claim for services covered under your plan. To avoid having your claim returned, please be sure all information is correct and complete. For Major Medical claims, complete front of form and attach bills. For doctor's services have your physician complete the reverse side of this form after you complete the front.

THIS SIDE OF FORM IS TO BE COMPLETED BY MEMBER

1. Member's Name _____ Social Security No. _____
Last First Initial Home Telephone No. _____
2. Home Address _____
Street Number and Name City State and Zip Code
3. Name of Member's Employer _____ Local Union No. _____
4. Patient's Name _____ Patient's Sex Male Female Birth Date _____
Month Day Year Married Single Widowed Divorced Legal Separation
Relationship to Member Self Spouse Child If child is age 19 or older: Is he/she a full time student? _____ School _____
5. Symptoms of Illness or Injury requiring treatment _____
6. Was the treatment required as a result of an accidental injury? Yes No If Yes, complete the following:
Date/Place of Injury _____ How injury occurred _____
7. Is Spouse Employed? Yes No If Yes, Complete the following:
Name of Employer _____ Address of Employer _____
8. Is patient covered under other insurance offering benefits for Hospitalization, Surgical, Medical or Dental Expenses?
 Yes No If Yes, complete the following:
Name of Insured _____ Name of Insurance Co. _____
Date of Birth _____
Address of Insurance Co. _____ Policy, Contract, or Identification Numbers _____
9. Is patient covered under Medicare? Yes No If Yes, attach form from Medicare and an itemized bill.
10. Was illness or injury caused by employment? Yes No If Yes, do not submit claim to Medical Fund. Submit to Worker's Compensation Insurance Company.
11. Do you wish payment to be made directly to the Provider? Yes No
12. I certify that the above information is correct and that I have coverage with the Medical Fund. I apply for benefits under this coverage and authorize any physician, nurse, hospital, or other providers or suppliers in possession of information concerning the patient to furnish such information to the Medical Fund upon request.
Date _____ Signature of Member _____

COMPLETE FOR ACCIDENT & SICKNESS WEEKLY BENEFITS ONLY

1. Provide date on which accident or sickness commenced. _____
2. How long were or will you be physically unable to work. From _____ Through _____
3. Last date worked. _____ Return to work. _____
4. Last Employer Preceding disability. _____
Date _____ Signature of Member _____

