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| Beech Street A VIANT NETWORK MultiPlan | **Beech Street Preferred Provider Network Plan** | **MAIL FORM TO:**<br>**Klais & Company, Inc.**<br>**Benefit Consultant and Administrators**<br>**1867 West Market Street**<br>**Akron, Ohio 44313-6977**<br>**Tele: 800-331-1096** | ***Combined Life Insurance Company of New York*** |

**TO BE COMPLETED BY STUDENT**

1. **School Name** Schenectady County Community College **Policy #:** CUH201869
2. **Insured Student:** _____ **Group #:** SF720C0 & SF720D0
3. **Local Address:** _____
4. **Home Address:** _____
5. **Date of Birth:** _____/_____/_____ **Local Phone:** _____ **Home Phone:** _____
6. **Patient Status:** ☐ Male ☐ Female ☐ Single ☐ Married **Plan Member ID** _____

   **Is this Claim for a dependent?** ☐ Yes ☐ No **If yes, give name:** _____

   **Relationship:** _____ **Date of Birth:** _____

**COMPLETE THIS SECTION FOR ACCIDENT CLAIM**

7. **Is this claim the result of an accident?** ☐ Yes ☐ No **If yes, give date of accident:** _____/_____/_____ **Time of Accident:** _____
8. **Is this claim the result of a work-related injury?** ☐ Yes ☐ No

   **Is this claim the result of an auto accident?** ☐ Yes ☐ No

   **Is this claim the result of sports participation?** ☐ Yes ☐ No **If "yes"** ☐ intercollegiate ☐ intramural ☐ club ☐ other
9. **Where did the accident occur?** _____

   **How the accident did happen?** _____

**COMPLETE THIS SECTION FOR SICKNESS CLAIM**

10. **Name of physician:** _____ **Date of initial service:** _____/_____/_____
11. **Description of Illness:** _____
12. **Has the patient been treated for the above condition(s) in the last 12 months?** ☐ Yes ☐ No

    **If"yes" give condition(s) treated for and date(s) of treatment:** _____

**COMPLETE THIS SECTION FOR ALL CLAIMS (ACCIDENT OR SICKNESS)**

13. **Is patient covered for benefits by any Group Health, Employer, Union, Welfare Plan or Parent Health Plan?** ☐ Yes ☐ No

    **Other coverage provided through: Name of Person** _____ **Relationship** _____

    **If answered "yes" please complete the following:**

    **Insurance Co. or Benefit Plan** _____ **Employer or Sponsor** _____

    **Address** _____ **Address** _____

    **Telephone:** _____ **Telephone** _____

    **Policy #** _____ **Please include a photocopy of other plan identification card, if available**

14 **To be completed regardless of age of patient:**

**Is patient covered under MEDICARE Hospital Insurance (Part A)** ☐ Yes **Eff. Mo.** _____/**Day** _____/**Yr.** _____ ☐ No

**Is patient covered under MEDICARE Hospital Insurance (Part B)** ☐ Yes **Eff. Mo.** _____/**Day** _____ /**Yr.** _____ ☐ No

15. **I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacist to release any information requested with respect to this claim.**

**It is unlawful to knowingly provide false, incomplete or misleading facts or information regarding a claim for the purpose of defrauding or attempting to defraud to receive benefits. Penalties may include imprisonment, fines, denial of benefits and/or civil damages. For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.**

**Signature of Insured Student** _____ **Date** _____ **20** _____

**Patient's or Authorized Person's Signature**_____ **Date** _____ **20** _____

**COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER(S)**

Authorization to Pay Benefits: I hereby authorize payment directly to: any physician or provider of service for which I am submitting attached billings and charges.
For the expenses provided under my Group Medical Expense Benefits, I understand I am financially responsible for charges not covered by this authorization

Signature