CLAIM FORM

Submit completed form to:
Significa Benefit Services, Inc.
P.O. Box 7777, Lancaster, PA 17604-7777
Fax: 717-581-8379

For secure submission of claims
with PHI, go to:
www.significabenefits.com\members
select "Submit Secure Email or Attachment"

COMPLETE FOR ALL CLAIMS – Please print

Employer Name:______________________ Employee Name:______________________
Home Address:____
Group#:__________ Member ID#:__________ Daytime Phone #:__________________

Patient Information

Claim is for: ☐ You (Employee) If checked, go to next section ☐ Dependent If checked, complete below
Name:______________________ Relationship: ☐ Spouse ☐ Child Birthdate:______________
Month / Day / Year

Accident and Injury Information

Type: ☐ Auto ☐ Work Related ☐ Other Date of accident:______________ Date treated:__________
Description of accident: (Where When and How did it happen):______________________________
____

Was another party responsible for the injury: ☐ Yes ☐ No If "Yes", complete the following:
Name and address of other party:______________________________
____
Name and address of other insurance company(ies) involved:______________________
____
Name and address of your attorney (if you have retained one):______________________
____
Name and address of police station (if a police report was filed):______________________
____

Attach copies of police reports, accident forms or claims submitted to other insurance carriers.

Authorization to Pay Benefits

☐ Pay doctor/hospital directly. If checked, you authorize payment to go directly to the doctor or hospital or to a participating/panel provider.
☐ You have paid the bill.

Other Medical Benefits/Health Insurance

Are you, your spouse or dependents also covered for medical benefits through any other employer, welfare plan or Medicare? ☐ Yes ☐ No
If "Yes", complete the following and attach the itemized bill along with a copy of the Explanation of Benefits (EOB). If an EOB from the other plan or Medicare is not available, please provide the name and address of the company providing benefits:
Name of person covered:______________________ Social Security Number:______________
Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Surviving spouse ☐ Other (Please specify)______________
Is spouse or dependent also employed? ☐ Yes ☐ No. If "Yes", Health Benefit Company Name & Contact #:
____

Employee Certification (must be signed by dependent (if not a minor) if this is their claim.

Notice: Any person who knowingly and with intent to defraud any insurance company or plan, files a statement of claim containing any materially false information or conceals information for the purpose of misleading, *commits* a *fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

Employee Signature:______________________________ Date:______________
Dependent Signature (if needed):______________________________