MUTUAL ASSURANCE ADMINISTRATORS, INC.

800.825.3540
405.848.1975

HEALTH BENEFITS SUBMISSION FORM

If these questions are answered COMPLETELY, it will help avoid delays in processing your claim. (1) Attach bills showing Patient's name, date, type of service, diagnosis and amount charged. Drug bills must also show prescription (Rx) numbers. (2) A separate claim form must be completed for each Covered Dependent, and those bills attached to them. (3) Return all claim forms and bills to Mutual Assurance at the address provided below.

PART A – EMPLOYEE INFORMATION

EMPLOYEE NAME	SOCIAL SECURITY NUMBER
HOME ADDRESS	MARITAL STATUS
GROUP PLAN NUMBER:	EMPLOYER NAME:
IS YOUR SPOUSE EMPLOYED? ❐ YES ❐ NO SPOUSE NAME:	SPOUSE'S EMPLOYER (Name, Address and Phone)

PART B – PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH	SEX ❐ MALE ❐ FEMALE

RELATIONSHIP OT EMPLOYEE
❐ SELF ❐ SPOUSE ❐ CHILD ❐ STEPCHILD ❐ OTHER _________

DOES THE PATIENT RESIDE WITH YOU ON A FULL-TIME BASIS ❐ YES ❐ NO

IF OTHER THAN SPOUSE, IS THE PATIENT A FULL-TIME STUDENT? ❐ YES ❐ NO, IF NO, PLEASE GIVE THE PATIENT'S PERMANENT ADDRESS AND FULL NAME OF GUARDIAN:

IF YES AND OVER 19, PLEASE PROVIDE NAME AND ADDRESS OF SCHOOL:

IS CHILD MARRIED? ❐ YES ❐ NO	IS THE CHILD EMPLOYED FULL-TIME? ❐ YES ❐ NO
DOES THE PATIENT HAVE OTHER INSURANCE COVERAGE? ❐ YES ❐ NO	IF YES, WHAT TYPE: ❐ GROUP ❐ INDIVIDUAL ❐ MEDICARE ❐ OTHER PROVIDE NAME, ADDRESS AND PHONE NO. OF OTHER INSURANCE COMPANY
REASON FOR CLAIM IF ACCIDENT ❐ Illness ❐ Accident ❐ Work Related ❐ Auto	DATE OF ACCIDENT: ______________________ BRIEFLY DESCRIBE
IS THE PATIENT DISABLED ❐ YES ❐ NO	IF YES, LAST DATE WORKED: ______________________________ DISABLED FROM ____________________ TO __________________

PART C – AUTHORIZATION

READ CAREFULLY

I hereby authorize any physician, dentist, medical practitioner, hospital, clinic, pharmacy or any other provider of health care, any insurance company, government agency or consumer reporting agency to disclose to Mutual Assurance Administrators or my employer, all information and records relating to a diagnosis, treatment, medical history, physical or mental condition and evaluation, or any other information relating to me or my dependents. The information authorized for release may include information which may be considered a communicable or venereal disease which may include, but is not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and the human immunodeficiency virus, also known as the Acquired Immune Deficiency Syndrome, (AIDS) or Aids Related Complex (ARC). I understand that any information obtained may not be released to any person or entity except its reinsurers, other persons or organizations conducting business or legal services in connection with my coverage, or as may be required by law, or as I may further authorize. A photocopy of this Authorization is as valid as the original and remains valid for the term of coverage. I have a right to receive a copy of this Authorization upon request.

EMPLOYEE SIGNATURE: ____ DATE: ______________________
(If claim is on spouse)
SPOUSE SIGNATURE: ____ DATE: ______________________

I REQUEST ALL BENEFITS AVAILABLE BE PAID DIRECTLY TO THE PROVIDER: ❐ YES ❐ NO

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE BY LAW.

P.O. BOX 42096 Oklahoma City, OK 73123-3096