Golden Rule®
A UnitedHealthcare Company

Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, Indiana 46278-1719

Claimant's Statement and Authorization

Include your identification number on all claims.
Incomplete or incorrect answers may delay processing of your claim.
If you have any questions, please call 1-800-657-8205.

PART A: Complete for all claims.

Policy/Certificate Number _____ Patient _____ Birthdate ___/___/___
Primary Insured _____ Home Phone (__) _____ Office Phone (__) _____
Address _____ City _____ State _____ Zip _____

Fill this out

Is the above address a new and permanent address? ☐ Yes ☐ No
Is the patient: In school full-time? ☐ Yes ☐ No Employed? ☐ Yes ☐ No

Do you or any family members have other coverage (medical, indemnity, or liability) which might help cover hospital and medical expenses? ☐ Yes ☐ No If yes:

Name of Company	Phone Number	Address	Policyholder	Policy/ Certificate No.	Is this group insurance?

PART B: Complete for new claims. If you need additional space, please write on the back.

1) How did the condition begin? State fully all symptoms and describe the condition in detail, from the beginning.

2) When did the first symptom of this condition begin? State the exact date, if possible. See attached superbill

3) Have you ever had or been treated for the same kind of illness or injury? ☐ Yes ☐ No If yes, when? _____
Name and address of attending physician See attached superbill

4) Name and address of family physician (even if not consulted) Tayma S. Shaya M.D

5) What ailments, diseases, illnesses, or injuries has the covered person had in the past five years? Please provide name and/or description of each condition, dates involved, and name and address of physicians. _____
See attached superbill

6) Is the condition the result of an accident or illness: No
a) Related to employment? No If yes, are you applying for Worker's Compensation benefits? No
b) Involving a motor vehicle? No If yes, please list the names of involved parties, insurance carriers, & policy numbers.
Was a police report filed? N/A With what agency? _____

PART C: Complete for all claims.

I verify that all information contained in this form is true, correct, and complete to the best of my knowledge.

To process a claim for benefits, I authorize any health care provider or facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis, or prognosis of any physical or mental condition, or the financial and employment status of the patient, employee, or deceased named below, to provide any or all of this information to Golden Rule Insurance Company, a UnitedHealthcare company, or any agent or independent administrator acting on its behalf.

I understand that I have the right to receive a copy of this authorization upon request, and that I have the right to revoke any authorization by notifying Golden Rule Insurance Company in writing. I understand that revocation of or failure to sign an authorization may impair Golden Rule Insurance Company's ability to evaluate or process a claim, and may be the basis for denying claims for benefits.

A copy of this shall be as valid as the original. This authorization is valid for 12 months from the date signed.

_____ X _____ _____

Please Print Name of Patient or Deceased | Signature of Patient, Authorized Representative, or Next of Kin | Date

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Directions for Submitting a Claim

Thank you for purchasing your medical coverage from Golden Rule Insurance Company. It is our goal to provide you with prompt and fair claim service. To assure that you receive the best claim service possible, we ask you for the following assistance:

- If you are filing a claim for a new illness or injury, please complete this entire form.
- If you are submitting additional claims for a continuing illness or injury, you need only complete sections A and C.
- Please include all medical bills which you wish us to process. Be sure that each bill indicates the patient's name, your insurance identification number, the date medical services were provided, the charge for each service, and the diagnosis for the condition treated.

NOTE: If you are on Medicare, or have other health insurance coverage, please include your Medicare or other carrier Explanation of Benefits for your expenses when submitting the expenses to us for consideration.

If a medical care provider files your claim directly, you will automatically receive an *Explanation of Benefits* (EOB) form and/or other correspondence from us. The available insurance benefits will be sent directly to the medical care provider. However, if you have already paid the bill, the available insurance benefits will be sent to you.

Our customer service line is open Monday through Thursday from 7 a.m. to 6 p.m. (CST) and Friday from 7 a.m. to 5 p.m. (CST). A representative can assist you with any questions regarding your claim.

WARNING:
For your protection state law requires the following to appear on this form:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.