

AFTRA HEALTH FUND

2008

(PLEASE SEE REVERSE SIDE FOR FILING INSTRUCTIONS)

PARTICIPANT INFORMATION

CHECK BOX IF NEW ADDRESS

AFTRA ID#:

PARTICIPANT NAME

CIGNA AMI:

STREET ADDRESS

CITY

STATE

ZIP

PATIENT INFORMATION

PATIENT NAME

RELATIONSHIP

BIRTH DATE

FULL TIME STUDENT

YES

NO

IS INJURY OR ILLNESS THE RESULT OF AN ACCIDENT?

YES

NO

IS INJURY OR ILLNESS WORK RELATED?

YES

NO

If the answer to either of the last two questions is Yes, please advise us of the nature of the accident or work injury, including the name of the company or insurance carrier involved in the space provided on the back of this form.

ARE YOU OR THE PATIENT COVERED BY ANY OTHER GROUP PLAN(S)?

YES

NO

IF YES: NAME OF INSURED UNDER THE GROUP PLAN

IF YES: NAME OF INSURED UNDER THE GROUP PLAN

NAME OF GROUP PLAN

NAME OF GROUP PLAN

ADDRESS OF GROUP PLAN

ADDRESS OF GROUP PLAN

POLICY #

POLICY #

EFFECTIVE DATE

EFFECTIVE DATE

(If the patient is covered under more than two group plans, you can add a third plan on the back of this form or use a separate piece of paper if you need more space.)

Any person who, knowingly and with the intent to defraud, files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. I authorize the release of all information needed for the purpose of processing this claim.

Participant's Signature: _____ Date: _____

PARTICIPANT'S ASSIGNMENT (OPTIONAL - READ BEFORE SIGNING)

I hereby authorize the AFTRA Health Fund to pay directly to the physician or other providers the benefits to which I am entitled to the extent of their interest as established by the attached bill (s).



Provider's Name

(Participant's Signature)

