

CUBS Health Solutions Plan Claim Form

(For Hospitalization and Surgery Benefits)

Return Completed Form To:
Pioneer Management Systems
P.O. Box 9040
West Springfield, MA 01090
1-866-653-2542



INSTRUCTIONS FOR FILING A CLAIM

FOLLOW INSTRUCTIONS CAREFULLY TO PREVENT DELAY OR RETURN OF THIS CLAIM FORM.

- A. Complete this form when filing claims for in-patient hospitalization or surgery charges -include appropriate signatures.
- B. Submit this form with a copy of an itemized bill to Markel Insurance Company for processing. If the diagnosis is not shown on the itemized bill, please have your doctor complete the back of this form.
- C. Benefits are not assignable.

Name of Insured Member/Employee (Last, First, MI)			Name of Employer/Sponsor		
Insured Member/Employee's Address (Street, City, State, Zip Code)			Is this a new address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Number	
Phone No.	Date of Birth	SSN		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	

PATIENT INFORMATION

Name of Patient (Last, First, MI)		Relationship to Insured Member/Employee	Date of Birth	SSN	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Is hospitalization the result of an accidental injury? If so, please describe how, when and where the accident occurred:				<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis / Reason for Hospitalization
Did the accidental injury or sickness arise out of or in the course of any work for pay or profit?					<input type="checkbox"/> Yes <input type="checkbox"/> No

Please list any hospitals, clinics or physicians that treated the patient during the past year:

Name	Address	Date	Reason

- If patient is a dependent child, is he or she under age 19? Yes No
- If patient is 19 but under 26, is he or she a full-time student? Yes No
- If so, please provide name and address of school:

AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically-related facility, insurance or reinsuring company, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give MARKEL INSURANCE COMPANY or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by MARKEL INSURANCE COMPANY to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MARKEL INSURANCE COMPANY to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for the duration of the claim.

FRAUD STATEMENT REQUIRED BY SOME STATES: "Any person who knowingly and with intent to defraud any insurance company or other person 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." **Florida:** "Guilty of a felony of the third degree;" **New Jersey:** "Subject to criminal and civil penalties;" **New York:** "Civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation;" **Pennsylvania:** "Subject to criminal and civil penalties."

Insured Member/Employee's Signature	Date	Spouse Signature (if patient)	Date
-------------------------------------	------	-------------------------------	------

PLEASE NOTE

In furnishing this or other claim forms for the convenience of the claimant, the MARKEL INSURANCE COMPANY does not admit any liability or waive any rights. MARKEL INSURANCE COMPANY reserves the right to ask for other information if it is deemed necessary. All expenses incurred in connection with furnishing the necessary proof of loss are the responsibility of the covered person.

PHYSICIAN'S CERTIFICATE - This section must be completed by the attending physician if no diagnosis is shown on the itemized hospital bill accompanying this claim form.

PATIENT'S NAME		
DIAGNOSIS AND CONCURRENT CONDITION (IF FRACTURE OR DISLOCATION, DESCRIBE NATURE & LOCATION)		
WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?		
WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?		
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? IF YES, STATE WHEN AND DESCRIBE. <input type="checkbox"/> Yes <input type="checkbox"/> No		
NATURE OF SURGICAL PROCEDURE, IF ANY (DESCRIBE FULLY)		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date Performed: _____
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		
REMARKS		
PRINT PHYSICIAN'S NAME	DEGREE	TAX ID NUMBER
STREET ADDRESS	CITY OR TOWN	STATE
PHYSICIAN'S SIGNATURE		TELEPHONE NUMBER
		DATE SIGNED