Instructions: Complete this form, attach your itemized statement or prescription receipt and return to Stirling Benefits, Inc.

StirlingBenefits™ Claim Administrators	**BENEFIT CLAIM FORM** **20 Armory Lane, Milford, CT 06460** **(203) 876-1660 (800) 447-6689** **Fax (203) 876-1465**	**CURRENCY CONVERSION FACTOR** **U.S. $1.00 = _____** **COUNTRY: _____**

Failure to Answer All Questions May Delay Payment

EMPLOYEE/COBRA PARTICIPANT INFORMATION (Please print)	First Name / Initial / Last Name			Social Security #
	Street Address / City / State / Zip			Date of Birth
	Employer's Name	Are you still employed? If no, date last worked Full-time:		Marital Status ☐ Legally Separated ☐ Single ☐ Divorced ☐ Married ☐ Widowed
IF CLAIM IS FOR A DEPENDENT, COMPLETE THESE SPACES	Patient's Name	Relationship		Date of Birth
	Name & Address of Patient's Employer or School			Full or Part-time?

Do you, your spouse or children have coverage under another Health Plan, including Retiree Coverage, Medicare, Medicaid or Champus? ☐ Yes ☐ No

If yes, give Name and Address of other Insurance Company/Retiree Plan Coverage:

When did illness begin, or accident occur? Date: **/ /**

If accidental injury, how, when, and where did it happen?

_____

If Sickness, please indicate condition being treated:

Is this claim related to: A. Employment (Worker's Comp) ☐ Yes ☐ No

B. Auto Accident ☐ Yes ☐ No

Patient was first treated on: Date **/ /**

By:

I hereby authorize payment directly to the Provider who rendered the services: ☐ Yes ☐ No
(If left blank, benefits will be made payable to the Employee, *unless Provider has assignment on file*.)

I hereby certify that the information on this form is complete and accurate to the best of my knowledge. I also agree to reimburse my employer to the extent of any overpayment, which is in excess of the amount payable under this group plan. I hereby authorize any person or institution rendering care, or any person or organization in possession of insurance, medical or other benefit information pertaining to me, or my dependents, to furnish full information regarding such care, insurance, treatment or other benefit information upon request to Stirling Benefits, Inc. I understand and agree that the information on my claim may be given to the Plan Administrator and its authorized agent and representatives, by Stirling Benefits, Inc. for statistical, audit, verification and loss control purposes.

_____ _____

Patient's Signature (if 18 years or older) Date Employee's Signature Date

A 11 OLF 1/2005

PLEASE USE THIS SPACE FOR COMMENTS/DETAILS REQUESTED BY CLAIM ADMINISTRATOR TO CONTINUE PROCESSING CLAIM: