CLAIMS IDENTIFICATION RECORD

P.O. Box 100043, Duluth, GA 30096-9343

Telephone (770) 623-8383

Name of Employee_____

Social Security No._____

Employer Name_____

Group No._____

If this claim relates to an accident, please provide accident details below. You may use the space below to attach itemized bills or receipts for dental services, vision services, or prescription drugs. Accident details must be submitted in writing by the insured.

FOR INTERNAL USE ONLY

Date Paid_____ Dependent #_____

Reason Pending:

_____Claim Form _____Accident Info _____Diagnosis

_____Itemized Stmt _____Hospital Audit _____Dep Eligibility

Other: