



CLAIM FORM

Mail, Fax or Email Claims To:
Boon-Chapman
P.O. Box 9201
Austin, TX 78766
Fax: 972-772-6097
Email: rockwallvision@boonchapman.com

MEDICAL DENTAL VISION

IMPORTANT: Itemized Bills for all covered expenses must accompany this Claim Form.

Employer: Group # Employee Id #

EMPLOYEE'S STATEMENT: TO BE COMPLETED BY THE EMPLOYEE

A: EMPLOYEE Name Date of Birth
(Last) (First) (MI) Month-Day-Year
Address Single Divorced
(Street) (City) (State) (Zip) Married Widowed

B: SPOUSE Name of Spouse Date of Birth:
Is Spouse Employed? (Answer Yes or No)
If Yes: Employer Phone # () -

C: PATIENT Myself Spouse Child (Name) DOB
If Child: Is Child Employed? Is Child Married?
Is Child a Full Time Student?
Name of Employer or School

D: THE CLAIM Injury Date Where did it Happen?
Medical How did Accident Happen?
Was Accident Connected to Patient's Employment? (Yes or No)
Illness When did Symptoms Begin?
When did you first see a Doctor? Doctors Name
Were you Hospital Confined? (Yes or No) Hospital Used

E: OTHER COVERAGE

Is Patient Covered by One of More of the Following, Including Any Carried by your Spouse:
A: Any other Medical or Dental Insurance or Plan? Yes No
If yes is this a Group or Individual Plan?
B: Any Federal, State, or Other Government Insurance Plan? Yes No
C: Any Medical or Dental Plan Sponsored by a School or College? Yes No
IF ANSWER TO ANY OF THE ABOVE IS "YES" PLEASE ATTACH COPY OF PLAN ID CARD OR PLAN BOOKLET TO THIS CLAIM FORM:

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, or other medical or medically related facility, insurance company, or other organization, institution, or persons that has any records or knowledge of me or of any member of my family, or my (our) health to release to Boon-Chapman any and all information with respect to any illness or injury, medical history, consultations, prescriptions, or treatments, and copies of all hospital or medical records. This authorization is valid from the date signed for the duration of the claim, unless revoked in writing by me or my legal representative. The information I have provided on this form is true and correct to the best of my knowledge. I agree that a photographic copy of this authorization shall be valid as the original.

Signature of Participant

Date