

Claims should be mailed to:



c/o Kanawha Benefit Services, Inc., Administrator
Post Office Box 8050
Lancaster, SC 29721-8050

APPLICATION FOR BENEFITS

INDIVIDUAL INSURANCE

INSURED'S STATEMENT

YOUR APPLICATION FOR BENEFITS WILL BE DELAYED UNLESS ALL QUESTIONS ARE FULLY COMPLETED

1. PATIENT'S NAME		2. RELATIONSHIP TO INSURED Self Spouse Child Other		3. SEX M F		4. PATIENT'S BIRTHDATE MO DAY YEAR			5. IF FULL TIME STUDENT School City		
6. INSURED'S NAME						7. POLICY NUMBERS					
8. INSURED'S MAILING ADDRESS Street City, State, Zip						9a. INSURED'S SOCIAL SECURITY NUMBER			9b. DRIVER'S LICENSE NUMBER		
						10. INSURED'S TELEPHONE NUMBER					
11. IF CONFINED, HOSPITAL NAME AND ADDRESS DATES OF CONFINEMENT: FROM _____ TO _____						12. WAS TREATMENT REQUIRED BECAUSE OF AN INJURY <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, DID INJURY OCCUR WHILE AT WORK <input type="checkbox"/> Yes <input type="checkbox"/> No DATE AND TIME OF ACCIDENT DESCRIBE HOW HAPPENED AND TYPE OF INJURIES					
13. IF COVERED BY OTHER SIMILAR INSURANCE, INDICATE COMPANY NAME AND ADDRESS (LIST ALL OTHERS)											

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

AUTHORIZATION

I hereby authorize any physician, hospital, pharmacy, employer, dentist, coroner/medical examiner, law enforcement agency, insurance organization, consumer reporting agency or other person or entity possessing any medical information, any information about insurance policies/benefits, or any other information to release all information to Kanawha Benefit Services, Inc., Administrator for Metropolitan Life Insurance Company. This includes any drug, alcohol, psychiatric, HIV infection or AIDS related treatment. A photocopy shall be as valid as the original. This authorization is valid 12 months from the date signed.

Date

Signature

Address

If signed on behalf of another, give relationship: _____

INSTRUCTIONS FOR FILING A CLAIM

Section 1 - Insured's Statement: Must be completed each time you file a claim. Be sure to answer every question. Sign and date the AUTHORIZATION for your doctor to release information to KANAWHA BENEFIT SERVICES, INC., Administrator for METROPOLITAN LIFE INSURANCE COMPANY.

Section 2 - Assignment of Benefits: Complete items 1, 2 and 3. If you wish to assign benefits to your doctor sign and date item 4.

Section 3 - Physician's Statement: Ask your doctor to complete this section. All questions should be answered.

SPECIAL INSTRUCTIONS:

Cancer Policy: Positive proof of Cancer must be furnished to establish a claim. Positive proof may consist of a pathology report or, in the event no surgery was performed, laboratory or X-ray reports. These reports must be attached to the claim form.

Any Policy providing benefits based on hospital confinement or indemnity benefits: Itemized copies of your bills must be attached to the claim form.

