

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	
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)									

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application of files a claim containing a false or deceptive statement is subject to prosecution and punishment for insurance fraud.

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: _____

EMPLOYER'S STATEMENT

1. EMPLOYEE'S NAME		2. DATE EMPLOYED	
		DATE TERMINATED	
3. JOB TITLE AND DUTIES			
4. WAS THIS AN INJURY		DETAILS	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
5. DATE LAST WORKED	6. HAS EMPLOYEE RETURNED TO WORK <input type="checkbox"/> Yes <input type="checkbox"/> No	7. DATE RETURNED TO WORK	

COMPANY NAME & ADDRESS

COMPLETED BY:

Signature

Date

Telephone

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 - Employer's Statement: Required only when you are filing a claim for Disability Benefits. This section must be fully completed by your supervisor or personnel office staff. Benefits cannot be paid beyond the date this section is completed.

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

Section 4 - 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.

ASSIGNMENT OF BENEFITS

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1. PATIENT'S NAME AND ADDRESS	2. DATE OF BIRTH
	3. POLICY NUMBER
4. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN FOR SERVICE DESCRIBED BELOW	
DATE: _____ SIGNED: _____	

PHYSICIAN'S STATEMENT

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1. DATE OF ILLNESS (FIRST SYMPTOM), INJURY (ACCIDENT) OR PREGNANCY (LMP)	2. DATE FIRST CONSULTED FOR THIS CONDITION	3. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. DATE PATIENT ABLE TO RETURN TO WORK	5. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	6. DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____				
7. NAME OF REFERRING PHYSICIAN		8. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____				
9. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)		10. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE <input type="checkbox"/> Yes <input type="checkbox"/> No				
11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. <u>RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE</u> 1. 2. 3. 4.						
12.	A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS
13. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____ DATE _____		14. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) <input type="checkbox"/> Yes <input type="checkbox"/> No		15. TOTAL CHARGE	16. AMOUNT PAID	17. BALANCE DUE
20. YOUR PATIENT'S ACCOUNT NO.		18. YOUR SOCIAL SECURITY NO.		19. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
21. YOUR EMPLOYER I.D. NO.						

PLEASE DETACH AND MAINTAIN FOR YOUR RECORDS

DATE CLAIM MAILED: _____

CHARGES SUBMITTED:

PROVIDER NAME	DATE OF SERVICE	CHARGE
_____	_____	_____
_____	_____	_____
_____	_____	_____