NCFlex SUPPLEMENTAL MEDICAL PLAN CLAIM FORM

Mail completed Claim Form to:
Kanawha Insurance Company
P. O. Box 2000
Lancaster, SC 29721-2000

INSURED'S STATEMENT — Must Be Completed For All Claims

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

1. PATIENT'S NAME	2. RELATIONSHIP TO INSURED				3. SEX		4. PATIENT'S BIRTHDATE			5. IF FULL-TIME STUDENT	
	Self	Spouse	Child	Other	M	F	MO	DAY	YEAR	School	City

6. INSURED'S NAME	7. CERTIFICATE NUMBERS
8. INSURED'S MAILING ADDRESS Street City, State, Zip	9a. INSURED'S SOCIAL SECURITY 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 ☐ YES ☐ NO IF YES, DID INJURY OCCUR WHILE AT WORK ☐ YES ☐ NO

13. DESCRIBE HOW HAPPENED AND TYPE OF INJURIES

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or 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 Insurance Company. This includes any drug, alcohol, psychiatric, HIV infection or AIDS related treatment. A photocopy shall be as valid as the original. The authorization is valid six months from the date signed.

____________ Date ____________ Signature ____________ Address

If signed on behalf of another, give relationship:____________

This Claim Form is for NCFlex Supplemental Medical Plan only.

INSTRUCTIONS FOR FILING A CLAIM

Insured's Statement: Be sure to answer every question. Sign and date the AUTHORIZATION for your doctor to release information to KANAWHA.

SPECIAL INSTRUCTIONS:

Itemized copies of your bills must be attached to the claim form.

A Claim form is not required. When submitting a claim without a claim form, please submit the receipt from your doctor (showing the diagnosis code) with your certificate number clearly written on the receipt. This can be faxed to our claims department at 803-283-5545 or mailed to the address above.