TO BE COMPLETED BY EMPLOYEE

INFORMATION ON SPOUSE AND/OR DEPENDENTS MUST BE COMPLETED IN FULL BEFORE A CLAIM WILL BE PROCESSED.

1	EMPLOYERS' NAME			GROUP #	
	EMPLOYEE MVP I.D. NO.		EMPLOYEE'S SOCIAL SECURITY NUMBER		
2	NAME OF EMPLOYEE	☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ SEPARATED		BIRTHDATE ☐ MALE ☐ FEMALE	TELEPHONE NO. ( )
3	ADDRESS OF EMPLOYEE-NUMBER AND STREET	CITY	STATE	ZIP CODE	☐ ACTIVE ☐ RETIRED
4	NAME OF PATIENT	PLAN I.D.#		BIRTHDATE ☐ MALE ☐ FEMALE	RELATIONSHIP
5	EMPLOYER (IF ANY) OF SPOUSE OR DEPENDENT CHILD				
6	IF STUDENT, NAME OF SCHOOL PRESENTLY ATTENDING	CITY	STATE	ZIP CODE	TELEPHONE NO. ( )
7	IS PATIENT ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO	IS PATIENT HANDICAPPED? ☐ YES ☐ NO		IS PATIENT FULL-TIME STUDENT OVER AGE 18? ☐ YES ☐ NO	
8	DO YOU OR ANY OF YOUR FAMILY MEMBERS HAVE ANY OTHER HEALTH INSURANCE? ☐ YES ☐ NO	IF YES: (A) INSURANCE CO. _____ (B) EMPLOYER (NAME AND ADDRESS) _____ (C) POLICY OR I.D. NO. _____			
9	NATURE OF ILLNESS				

10	IS CLAIM BASED ON ACCIDENT? ☐ YES ☐ NO	DID ACCIDENT HAPPEN WHILE WORKING? ☐ YES ☐ NO	AUTO ACCIDENT? ☐ YES ☐ NO	OTHER ☐ YES ☐ NO	DATE AND TIME OF ACCIDENT
11	DESCRIPTION OF ACCIDENT (HOW AND WHERE)				

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose if misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

ASSIGNMENT: I hereby authorize payment directly to the hospital, physician or dentist herein named. I understand I am financially responsible for charges not covered by this assignment.

Employee Signature ▶ _____ Date signed ▶ _____

AUTHORIZATION TO RELEASE: I hereby authorize MVP to release or obtain any information which may be necessary to administer this Group Plan. A photocopy of this authorization shall be valid.

Employee Signature ▶ _____ Date signed ▶ _____

Patient Signature ▶ _____ Date signed ▶ _____

(Parent should sign for minor child)

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