Q3 Business Technology Corp.
P. O. Box 15952
Fort Wayne, IN 46885

www.q3online.com
Phone 260.492.9979 877.251.8324
Fax 260.492.9989

Group Benefit Plan Claim Form

Note: Every item must be completed before claim can be processed! (please print in ink or type)

As shown on ID card, Plan Name: ___________________________________ ID #: ______________

As shown on ID card, Employee Name: _______________________________ ID #: ______________

Claimant Name: _________________________ Soc Sec #: ____________ Date of Birth: _________

Claimant Relationship to Employee: ❍ *Self* ❍ *Spouse* ❍ *Child*
Is the claimant employed? ❍ *Yes* ❍ *No* If an adult child, a full-time student? ❍ *Yes* ❍ *No*

Name of school or employer: ___________________________ Address: __________________________
City, State, Zip Code: ________________________________ Telephone #: _______________

Enrolled through: _______(date) Currently carrying:____ ❍ *Quarter hours* ❍ *Semester hours*
Please attach documentation from the school showing proof of enrollment

Is this claim a result of: ❍ *Illness* Date of First Symptom: ___________
❍ *Pregnancy* Expected Delivery Date: ___________
❍ *Injury* Date of Accident: ___________

Please provide details: ____

____

Is any other insurance involved? ❍ *Yes* (complete Other Coverage information below) ❍ *No*
Is this claim in any way occupational in nature? ❍ *Yes* ❍ *No*
Is this claim covered by Worker's Compensation? ❍ *Yes* ❍ *No*

Employee Marital Status: ❍ Married ❍ Legally Separated ❍ *Single*
Do any family members have coverage under any other Group or Insurance Plan (including employer provided coverage, private insurance, student insurance, COBRA, Medicare and Medicaid)? ❍ *Yes* (complete Other Coverage information below) ❍ *No*

Other Coverage (if applicable)

Plan Name: ____ Plan #: _______________

Plan Address: ____

Plan City, State, Zip Code: ____

Policy # or Enrollee ID #: _______________ Plan Telephone #: _______________

Family member(s) covered under Plan: ____
If there is more than one plan providing other coverage, provide additional information on the back of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health or that of my family listed on this form to give to my employer or its insurers any such information. A photographic copy of this authorization shall be as valid as the original. I hereby certify that the above answers are true and complete to the best of my knowledge and are the basis under which benefits are provided under this Plan. I have read and agree to abide by the Subrogation and Reimbursement provisions of this Plan contained in the Summary Plan Description.

____ ______________
Signature of Claimant (if an adult) Date

____ ______________
Signature of Employee Date