ASSURED BENEFITS
ADMINISTRATORS

CLAIM FORM

If you and your dependents are enrolled in a Medical/Vision and/or Dental Plan, please indicate below any other medical and/or dental plan coverage. This would include coverage through an employer, a spouse's plan, a parent plan, Medicaid, Medicare etc...

Please complete the information below in order to avoid delays in processing your claims and mail the response to:

Assured Benefits Administrators
PO Box 211517
Eagan, MN 55121-2717

Employee Name_____**Employer**_____

Employee's Soc. Sec. No._____

Address_____**City, State, Zip**_____

Phone #_____**Email address:**_____

Is there any other health coverage? Yes [ ] No [ ] If yes, please list the spouse and/or dependents:

Dependent Name:_____

Other insurance carrier_____ Elig. Dates_____

Dependent Name:_____

Other insurance carrier_____ Elig. Dates_____

Dependent Name:_____

Other insurance carrier_____ Elig. Dates_____

If you have any questions, we may be reached at (800) 247-7114 or (915) 532-2100.

Please sign and date this form and return back to Assured Benefits Administrators.

Signed _____ Date_____