ARGUS
Insurance • Pensions • Investments

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Health Insurance Claim Form

Please submit original receipts

A: Name of Employer	**Account / Location Name**
Group Policyholder	If different from Group Policyholder (Employer) Name
Group Number	Certificate Number

B: Insured Employee Information			
Last Name	First Name	M.I.	Date of Birth (month/day/year)

C: Patient Information			
Last Name	First Name	M.I.	Date of Birth (month/day/year)
Patient's Address			Telephone Number
Patient's Relationship with Insured		Sex	
☐Self ☐Spouse ☐Child		☐ Male ☐Female	
If other Insurance coverage (i.e. Supplementary coverage) please provide insurer and policy number, etc..			

D: Physical Information				
Was the Claim incurred as a result of:		month/day/year		
☐ Traffic Accident	Date of traffic accident?		Was a third party involved?	☐ Yes ☐ No
☐ Job Accident	Date of job accident?			
☐ Pregnancy	Date of last menstrual period?			

Reason for visit / Diagnosis (Please attach **original** receipts)

Date of Service	Place of Service	Procedure Code	Description	Diagnosis Code	Charges	Currency	Days or units

Signature of Physician of Supplementary Professional: I certify that the statements on this claim form are correct.	Date (month/day/year)
Name and address of office submitting claim	Telephone Number

E: Declaration

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and authorise release of medical records related to the attached claims to Argus. I agree that a faxed copy of this release is acceptable to me. I understand that I am financially responsible for charges not covered by the Policy.

Signature of Patient or Authorised Person	Date **(month/day/year)**

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act , punishable under law and may be subject to civil penalties

F: Assignment of Insurance Benefits (Sign only for Direct Payment to Hospital , Physician or other providers)

I hereby authorise payment directly to the hospital, physician or other health care provider, named on attached claim form(s)

Signature of Insured Employee	Date **(month/day/year)**

All Claims must be made within 12 months of the date of treatment with original receipts
Eligibility for Benefits is determined by the terms and conditions of our policy.