CLAIM FORM
GROUP POLICY
285630

afspa
FOREIGN SERVICE BENEFIT PLAN
Caring For Your Health Worldwide

aetna®

☐ CHECK HERE IF NEW ADDRESS SINCE LAST SUBMISSION. DATE RELOCATED
____/____/____

FORWARD COMPLETED CLAIM FORM TO: **FOREIGN SERVICE BENEFIT PLAN**
1620 L STREET, NW, SUITE 800
Phone: (202) 833-4910 WASHINGTON, DC 20036-5629

PLEASE PRINT **TO BE COMPLETED BY INSURED MEMBER** **PLEASE PRINT**
All items must be answered in full before your claim can be processed.

Member's full name _____ Sex _____ Date of Birth _____
Member's mailing address _____
(Number and Street) (City) (State) (Zip Code)
Member's Subscriber ID w_____ Enrollment Code ☐ Self Only 401 ☐ Self Plus One 403 ☐ Self & Family 402
If claim is for a dependent, given name _____ Relationship _____ Date of Birth _____
Dependent's marital status (check one) ☐ single ☐ married
Name of dependent's employer _____
Describe Sickness/Accident Suffered SEE BILL
If Accident: (a) Date of accident _____
(Month) (Day) (Year) (Hour)
(b) How and where did accident occur? _____
Was accident or sickness work related? ☐ Yes ☐ No If "Yes" please contact your workers' compensation office for guidance.
Physician's Name _____ Address _____

OTHER INSURANCE/MEDICARE COVERAGE INFORMATION

(See section on coordination of benefits in your Brochure)

IMPORTANT: This question must be answered and the form signed before claim can be processed.

(a) Are you or any member of your family covered under any health plan other than FOREIGN SERVICE BENEFIT PLAN? ☐ Yes ☐ No
(b) If answer is "Yes", complete the following:
Person in whose name the other plan is issued _____
Name of all dependents covered under the other plan _____
Name of Insurance Company or Plan _____ Effective Date _____
Address of Claims Office _____
Is this insurance through active employment? _____ Employment Effective Date _____
Policy or Contract Number _____ Is Plan ☐ Family or ☐ Self only coverage? (Check appropriate block)
(c) Is this other plan issued under a ☐ Group or ☐ Individual contract? (Check appropriate block)

IMPORTANT: This question must be fully answered by persons age 65 or older and persons under age 65 receiving disability benefits through Social Security.

Medicare coverage (see your official Brochure)
(a) Are you or any member of your family covered under Medicare? ☐ Yes ☐ No
(b) If "Yes", indicate name of person and check the type of coverage.
SELF: _____ ☐ Hospital (Part A) Effective Date _____ ☐ Medicare (Part B) Effective Date _____
SPOUSE: _____ ☐ Hospital (Part A) Effective Date _____ ☐ Medicare (Part B) Effective Date _____
DEPENDENT: _____ ☐ Hospital (Part A) Effective Date _____ ☐ Medicare (Part B) Effective Date _____
(c) If you or your spouse are 65 or over, indicate whether you are actively employed.
Self: ☐ Yes ☐ No Employer _____
Spouse: ☐ Yes ☐ No Employer _____

Authorization for direct payment of benefits.	I authorize payment directly to AMERICAN MEDICAL CENTER (Print name of physician) for the Medical and/or Surgical Benefits otherwise payable to me. Date _____, 20 _____ Signed _____ (Signature of member)

I certify the information on this form is complete and accurate.

Signature of patient or member	Date

WARNING: Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000, or imprisonment of not more than five years, or both. (18 U.S.C. 1001)

HAVE YOU ANSWERED EVERY QUESTION? _____ **HAVE YOU DATED AND SIGNED THIS FORM?** _____