KEMPER Health

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY

P.O. Box 9988
Austin, TX 78766-9988
Telephone: 844-613-6245 Fax: 844-473-8084
Email: service@kemperbenefits.com Website: kemperbenefits.com

SUPPLEMENTAL MEDICAL EXPENSE CLAIM FORM

Instructions to File a Claim:

- Complete the claim form *(Insured/Claimant Statement)*
- Sign and date the form (*Must be signed by the Insured person and Claimant (if an adult).*
- Be sure to include, along with your claim form:
  - Copy of the itemized bill *(with patient name, date of service, name of provider, type of service, diagnosis code).*
  - Copy of the Explanation of Benefits from your Health Benefit Plan.
- Mail, fax or email to the address or number above.

Insured/Claimant Statement

Insured's Name (Last, First, Middle)	Social Security No.	Date of Birth
Address (Street, City, State, Zip)		
Phone Number (With Area Code)	Email Address	
Claimant's Name (Person who is injured)	Date of Birth	Relationship to Insured
Describe condition for which claim is being made (if injury, give details of where and in what manner it occurred):		
Date symptoms first appeared, or accident happened:	If applicable, date last worked because of illness:	

Provider Name:	Address:	Diagnosis:	Dates of Treatment:
_____	_____	_____	_____
_____	_____	_____	_____

Is the patient's condition due to injury or illness arising out of or in the course of employment? ☐ Yes ☐ No

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO RESERVE NATIONAL INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINIAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HAVE REVIEWED THE IMPORTANT CLAIMS INFORMATION ON THE BACK OF THIS FORM.

DATE_____ INSURED'S SIGNATURE: _____

DATE_____ CLAIMANT'S SIGNATURE: _____