BOON-CHAPMAN

P.O. Box 9201 / Austin, TX 78766 / 512-454-2681 / 800-252-9653 / Fax 512-454-8700

1. Employer's Name: _____
2. Employee's Name: _____
3. Employee's Address: _____

3a. Check here if a new address: ❑Yes ❑No

4. Employee's Social Security Number:_____ Group Number:_____
5. Patient's Name: _____ Relationship:_____ Birthdate:_____
6. Was treatment the result of an occupational injury? ❑Yes ❑No
7. Was treatment the result of an accident? ❑Yes ❑No
8. If yes, please state below how, where, and when the accident occurred:_____

_____

9. Is patient covered by any other group medical plan? ❑Yes ❑No
10. If yes, give insured's name, SS#, and plan sponsor's name, address and phone number: _____

_____

11. Make benefits payable to: ❑Me ❑Provider (If you have assigned benefits, we must pay the provider.)

Authorization to Release Information:

I hereby authorize the physician/provider to release any information acquired in the course of my or my dependent's examination or treatment. I understand that such information will be used by Boon-Chapman for the purpose of verifying that the services charged for were provided and that my authorized representative or I will receive a copy of this authorization upon request. This authorization is valid from the date signed for the duration of the claim, unless revoked in writing by me or my legal representative. The information I have provided on this form is true and correct to the best of knowledge. I agree that a photographic copy of this authorization shall be as valid as the original.

_____ _____

Signature of Participant Date