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Employee #

# HOSPITAL INDEMNITY CLAIM FORM

## INSTRUCTIONS

The employee and the hospital must complete this form for each inpatient hospital admission.

This form should be used only when filing a claim for inpatient hospital indemnity benefits.

### To be Completed by Employee

1. Name of Employee (Last Name, First Name) <u>DOE, JOHN Q.</u>	Sex <input checked="" type="radio"/> M <input type="radio"/> F	Date of Birth <u>09-08-1908</u>	Social Security Number <u>000-000000</u>
2. Employed by (Name of Company) <u>Irving Independent School District</u>			
3. Have you Terminated Employment? <u>Yes</u> <input type="radio"/> <u>No <input checked="" type="radio"/></u>		If Yes, Date Terminated _____	
4. What is the last date you were actively at work? <u>5/25/2005</u>			
5. Describe the illness or injury requiring treatment <u>ABDOMINAL SURGERY TO REPAIR HERNIA.</u>			
6. Dates of this hospital confinement: <sup>★</sup> <u>ATTACH HOSPITAL DOCUMENTATION OF DATE OF ADMISSION &amp; DISMISSAL</u> <sup>★</sup> Admit Date <u>5/26/2005</u> Discharge Date <u>5/31/2005</u>			
7. If surgery was performed, please specify type of surgery and date performed. Type of Surgery _____ Date of Surgery <u>5/26/2005</u>			
8. Have you submitted a claim form for this hospital admission before? _____ Yes _____ <input checked="" type="radio"/> No			

The above statements are true and complete to the best of my knowledge and belief. I hereby authorize any hospital or physician who has treated me and any insurance company to furnish any and all medical information to Irving Independent School District. A photo static copy of this authorization shall be considered as effective and valid as the original.

Employee's Signature John Q. Doe Date 9/01 2005  
 Address 1923 Anywhere Blvd. #5006  
 City Somewhere State Tx Zip 00000  
 Telephone Number (972) 000-0000

**NOTE: All benefits are payable directly to the insured and are not assignable.**

For IISD office use only	
Date Received _____	
Date Approved _____	
Amount of Claim _____	
Amount Paid to Employee _____	
Date Paid _____	
Employee Benefits Representative signature: _____	
Date _____	

Submit This Claim Form to:  
Irving Independent School District

Benefits Office  
Irving ISD  
2621 W. Airport Freeway  
Irving, TX 75062

