

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)	Sex M F	Date of Birth	Social Security Number
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2. Employed by (Name of Company) Irving Independent School District

3. Have you Terminated Employment? Yes No
If Yes, Date Terminated _____

4. What is the last date you were actively at work? _____

5. Describe the illness or injury requiring treatment _____

6. Dates of this hospital confinement: (*ATTACH HOSPITAL DOCUMENTATION OF DATE OF ADMISSION & DISMISSAL*)
Admit Date _____ Discharge Date _____

7. If surgery was performed, please specify type of surgery and date performed.
Type of Surgery _____ Date of Surgery _____

8. Have you submitted a claim form for this hospital admission before? Yes 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 _____ Date _____ 20__

Address _____

City _____ State _____ Zip _____

Telephone Number (____) _____

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

For HISD 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

