A UnitedHealthcare Company

Golden Rule Insurance Company
PO Box 31374
Salt Lake City, Utah 84131-0374
FAX: (801) 478-7581

Claimant's Statement and Authorization

Include your identification number on all claims.
Incomplete or incorrect answers may delay processing of your claim.
If you have any questions, please call (800) 657-8205.

PART A: Complete for all claims.

Policy/Certificate Number ______________________ Patient ______________________ Birthdate_______/____/________

Primary Insured ____________________________ Home/Cell Phone (____)__________ Daytime Phone (____)__________

Address __________________________________ City ______________________ State_________ ZIP ____________

Is the above address a new address? ☐ Yes ☐ No Is above address a permanent address? ☐ Yes ☐ No

Is the patient employed? ☐ Yes ☐ No Name and Phone Number of Employer ____

Do you or any family members have other coverage (medical, indemnity, liability, or workers' compensation) which might help cover hospital and medical expenses? ☐ Yes ☐ No If yes:

Name of Company	Phone Number	Address	Policyholder	Policy/ Certificate Number	Is this group insurance?

PART B: Complete for new claims. If you need additional space, please write on the back.

1) How did the condition begin? State fully all symptoms and describe the condition in detail, from the beginning.

____

____

2) When did the first symptom of this condition begin? State the exact date, if possible. ____________________________

3) Have you ever had or been treated for the same kind of illness or injury? ☐ Yes ☐ No If yes, when? ______________

Name, address, and phone number of attending physician. ____

____

4) Name, address, and phone number of family physician (even if not consulted). ________________________________

____

5) What ailments, diseases, illnesses, or injuries has the covered person had in the past five years? Please provide name and/or description of each condition, dates involved, name, address, and phone number of physicians.

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6) Is the condition the result of an accident or illness:

a) Related to employment?__ If yes, are you applying for Workers' Compensation benefits? ______________________

b) Involving a motor vehicle?__ If yes, please list the names and phone numbers of involved parties, insurance carriers, and policy numbers.

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c) Was a police report filed? __ If yes, please list the name, address and phone number of the police department.

____

PART C: Complete for all claims.

I verify that all information contained in this form is true, correct, and complete to the best of my knowledge.

To process a claim for benefits, I authorize any health care provider or facility, pharmacy, government agency, insurance company, group policyholder, employee, or benefit plan administrator having information as to the care, advice, treatment, diagnosis, or prognosis of any physical or mental condition, or the financial and employment status of the patient, employee, or deceased named below, to provide any or all of this information to Golden Rule Insurance Company, a UnitedHealthcare Company, or any agent or independent administrator acting on its behalf.

I understand that I have the right to receive a copy of this authorization upon request and that I have the right to revoke any authorization by notifying Golden Rule Insurance Company in writing. I understand that revocation of or failure to sign an authorization may impair Golden Rule Insurance Company's ability to evaluate or process a claim, and may be the basis for denying claims for benefits.

A copy of this shall be as valid as the original. This authorization is valid for 12 months from the date signed.

______________________________	______________________________	______________
Please Print Name of Patient or Deceased	Signature of Patient, Authorized Representative, or Next of Kin	Date

Golden Rule®

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Directions for Submitting a Claim

Thank you for purchasing your medical coverage from Golden Rule Insurance Company. It is our goal to provide you with prompt and fair claim service. To assure that you receive the best claim service possible, we ask you for the following assistance:

- If you are filing a claim for a new illness or injury, please complete this entire form.
- If you are submitting additional claims for a continuing illness or injury, you need only complete sections A and C.
- Please include all medical bills which you wish us to process. Be sure that each bill indicates the patient's name, address and phone number, your insurance identification number, the date medical services were provided, the charge for each service, the procedure codes, and the diagnosis for the condition treated. In addition, we must have the provider's complete name, address, phone number, and credentials, as well as their Tax Identification Number (TIN) and National Provider Identifier (NPI) number.
- We must have complete itemized bills from your providers, instead of balance due statements.

NOTE: If you are on Medicare, or have other health insurance coverage, please include your Medicare or other carrier Explanation of Benefits for your expenses when submitting the expenses to us for consideration.

If a medical care provider files your claim directly, you will automatically receive an *Explanation of Benefits* (EOB) form and/or other correspondence from us. The available insurance benefits will be sent directly to the medical care provider. However, if you have already paid the bill, the available insurance benefits will be sent to you.

Our customer service line is open Monday through Friday from 7 a.m. to 5 p.m. (CT). A representative can assist you with any questions regarding your claim.

WARNING:
For your protection state law requires the following to appear on this form:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.