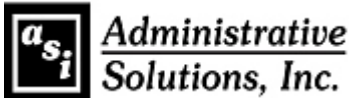


CLAIM FORM FOR MEDICAL AND DENTAL INSURANCE



Any person who knowingly and with intent to defraud or deceive fills out this form falsely or omits important facts may be guilty of a criminal act and subject to criminal penalties.

P.O. Box 2490 Alpharetta, GA 30023-2490 (678) 339-0211 fax (678) 339-3884

Group Plan No.		Company Name			
1. Last Name	First Name	Middle Initial	Social Security No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Married <input type="checkbox"/> Female <input type="checkbox"/> Single
2. Home Address				Home Telephone No. ()	
City	State	Zip Code	Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Retired <input type="checkbox"/> Salaried		
Is this person covered under any other medical and/or dental plan described below? a) Group, Individual and/or HMO insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No b) Government, Social Security and/or Medicare / Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No			Name the insurance plan or government program below:		

SPOUSE INFORMATION

3. Full Name of Spouse	<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse's Social Security No.	Date of Birth	Spouse Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Spouse's Employer
Is this person covered under any other medical and/or dental plan described below? a) Group, Individual and/or HMO insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No b) Government, Social Security and/or Medicare / Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No			Name the insurance plan or government program below:		

DEPENDENT CHILDREN INFORMATION

4. First Dependent Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of School	Relationship
Is this person covered under any other medical and/or dental plan described below? a) Group, Individual and/or HMO insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No b) Government, Social Security and/or Medicare / Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No			Name the insurance plan or government program below:		
5. Second Dependent Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of School	Relationship
Is this person covered under any other medical and/or dental plan described below? a) Group, Individual and/or HMO insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No b) Government, Social Security and/or Medicare / Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No			Name the insurance plan or government program below:		
6. Third Dependent Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of School	Relationship
Is this person covered under any other medical and/or dental plan described below? a) Group, Individual and/or HMO insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No b) Government, Social Security and/or Medicare / Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No			Name the insurance plan or government program below:		
7. Fourth Dependent Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of School	Relationship
Is this person covered under any other medical and/or dental plan described below? a) Group, Individual and/or HMO insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No b) Government, Social Security and/or Medicare / Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No			Name the insurance plan or government program below:		

Upon presentation of this original or a photocopy thereof, I authorize any medical professional, medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide, Administrative Solutions, Inc., or any agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, with all information regarding advice, care, treatment, and diagnosis about any medical condition, including use of drugs or alcohol concerning the patient herein. I also authorize any patient's or insured's employer, group policyholder or benefit plan administrator to provide ASI or the above-named parties with all other medical or employment information relevant to this claim. I understand that: ASI will use such information for evaluation and administration of claims for benefits. This authorization is valid from the date signed for the duration of the claim. I certify the information given by me is true and correct.

Signature: _____ **Date:** _____