



NCFlex SUPPLEMENTAL MEDICAL PLAN CLAIM FORM

Mail completed Claim Form to:
Kanawha Insurance Company
P. O. Box 2000
Lancaster, SC 29721-2000

INSURED'S STATEMENT — Must Be Completed For All Claims

YOUR APPLICATION FOR BENEFITS WILL BE DELAYED UNLESS ALL QUESTIONS ARE FULLY COMPLETED.

1 PATIENT'S NAME	2 RELATIONSHIP TO INSURED Self Spouse Child Other	3 SEX M F	4. PATIENT'S BIRTHDATE MO DAY YEAR	5. IF FULL-TIME STUDENT School City
6. INSURED'S NAME			7. CERTIFICATE NUMBERS	
8. INSURED'S MAILING ADDRESS Street City, State, Zip			9a. INSURED'S SOCIAL SECURITY NUMBER	
11. IF CONFINED. HOSPITAL NAME AND ADDRESS DATES OF CONFINEMENT: FROM _____ TO _____			10. INSURED'S TELEPHONE NUMBER	
11 IF CONFINED. HOSPITAL NAME AND ADDRESS			12. WAS TREATMENT REQUIRED BECAUSE OF AN INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES. DID INJURY OCCUR WHILE AT WORK <input type="checkbox"/> YES <input type="checkbox"/> NO	
13. DESCRIBE HOW HAPPENED AND TYPE OF INJURIES				

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is subject to prosecution and punishment for insurance fraud.

AUTHORIZATION

I hereby authorize any physician, hospital, pharmacy, employer, dentist, coroner/medical examiner, law enforcement agency, insurance organization, consumer reporting agency, or other person or entity possessing any medical information, any information about insurance policies/benefits, or any other information to release all information to Kanawha Insurance Company This includes any drug, alcohol, psychiatric, HIV infection or AIDS related treatment. A photocopy shall be as valid as the original. The authorization is valid six months from the date signed

_____ Date _____ Signature _____ Address

If signed on behalf of another, give relationship: _____

This Claim Form is for NCFlex Supplemental Medical Plan only.

INSTRUCTIONS FOR FILING A CLAIM

Insured's Statement: Be sure to answer every question. Sign and date the AUTHORIZATION for your doctor to release information to KANAWHA.

SPECIAL INSTRUCTIONS:

Itemized copies of your bills must be attached to the claim form

A Claim form is not required. When submitting a claim without a claim form, please submit the receipt from your doctor (showing the diagnosis code) with your certificate number clearly written on the receipt. This can be faxed to our claims department at 803-283-5545 or mailed to the address above.