SAG-AFTRA HEALTH PLAN

3601 W. Olive Ave., Burbank, CA 91505 • Mailing Address: P.O. Box 7830, Burbank, CA 91510-7830
P (800) 777-4013 • F (818) 953-9880 • www.sagaftraplans.org/health

Medical Claim Form

Instructions for filing a claim:
If you have other insurance as your primary coverage, submit your bills to your other health insurance carrier first. When you receive its Explanation of Benefits (EOB), attach a copy of it — along with an itemized bill — to this claim form and follow instructions 1 through 3 below for filing a claim with the SAG-AFTRA Health Plan (Plan).

1. **Complete this form** (required for each family member).
2. **Sign and date the form.** The participant must sign and date this form. In addition, the spouse's signature is required if the claim is for a spouse.
3. **Mail the form** to the mailing address indicated above ***or*** submit the form via our secure **Benefits Manager** messaging portal.

Participant information

Name:		Participant health care ID (HCID):	
Address:			
City:	State:	Zip:	New address? ☐ Yes ☐ No
Home phone: ( ) -		Work phone ( ) -	
☐ Single ☐ Married ☐ Legally separated ☐ Divorced ☐ Widowed			

Patient information

Name:		Birthdate: / /	
Does the patient have his/her own SAG-AFTRA Plan coverage? ☐ Yes ☐ No		Is patient covered by Medicare? ☐ Yes ☐ No	
Relationship to participant:	☐ Self ☐ Spouse ☐ Child		
Do you or other family members have medical health insurance other than the Plan? ☐ Yes ☐ No			

Other health insurance coverage? ☐ Yes ☐ No If yes, complete below:

Name of insured:			
Relationship:		Insurance ID #:	
Name of other insurance:			
Address:			
City:	State:	Zip:	Phone: ( ) -

Is this claim due to an accident? ☐ Yes ☐ No If yes, complete below:

Date of accident/injury: / /	Location:
How did it occur?	

Was illness or injury caused by the patient's job? ☐ Yes ☐ No If yes, complete below:

Date of accident/injury: / /	Time:
Employer:	
Have you/your dependent filed a claim for workers' compensation benefits? ☐ Yes ☐ No	

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, medical practitioners, hospitals, pharmacies, or other institutions rendering care and treatment to furnish the SAG-AFTRA Health Plan with full information regarding the care and treatment rendered (including copies of their records).

Participant signature _____ Spouse signature (required if claim is for spouse) _____ Date _____

Any person who knowingly and with intent to injure, defraud, or deceive files a statement of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law. Please be advised that no rights under the Plan, including but not limited to the right to receive any benefit or any right to pursue a Claim or cause of action, are assignable to another party. For more information see the "Authorized Representatives" section on page 102 of the SPD.