

Medical Expense Claim Form

This Claim Form with original itemized bills and all correspondence should be mailed to:

WALLACH AND COMPANY, INC.
107 West Federal Street
Post Office Box 480
Middleburg, Virginia 20118-0480

Within 90 days of the date you first received medical care.

DO NOT submit a claim unless your total expenses exceed your policy deductible.

Please complete all relevant sections of this Claim Form. A separate Claim Form must be completed for each illness or injury. Original documentation (itemized bills and receipts) must be submitted with this Claim form. Photocopies of documents are NOT acceptable.

IMPORTANT: This medical coverage is excess of any other type of insurance available to you. You must submit your claim to these insurance companies first, then send us their Statement of Benefits Paid or Denied.

PART A (please print) TO BE COMPLETED BY THE INSURED PERSON

Name of Insured Person: _____ Insurance I.D. No.: _____

Mailing Address: _____

Do you have any other personal medical insurance, or medical insurance through your employer, school or other organization?
 yes no If yes, please list the name, phone number and policy number of that insurance policy.

THIS SECTION MUST BE SIGNED BY THE INSURED PERSON

MEDICAL AUTHORIZATION

Upon presentation of the original or photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, government agency, insurance company, group policyholder, employer or benefit plan administrator to provide Pan-American Life Insurance Company or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, information concerning advice, care treatment provided to the patient or deceased named below, including information relating to mental illness, use of drugs or alcohol. I also authorize my group policyholder or benefit administrator to provide Pan-American Life Insurance Company with financial or employment related information.

I understand that such information will be used by Pan-American Life Insurance Company for the purpose of evaluating my claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed for the duration of the claim.

X _____ X _____ X _____
Name of Patient (or Deceased) Signature of Patient, Authorized representative Date Signed
Or next of kin (month/day/year)

(If patient is under eighteen (18) years of age or is incapacitated, Parent or Guardian must sign. If Patient is deceased, personal representative or next of kin must sign.)

AUTHORIZATION TO PAY BENEFITS TO THE PROVIDER OR MEDICAL

SERVICES: I hereby authorize payment directly to the provider of services, if any, otherwise payable to me for those services but not to exceed the reasonable and customary charge for those services.

X _____
Signature of Insured Person

PART B... If this claim is the result of an injury, please answer the following questions (1 thru 6)

1. Was the MEDEX Assistance Center notified? Yes No If yes, when: _____
2. Date and location of the injury: _____

3. Describe the injury and how it occurred: _____

4. Name and address of the physician or hospital where you were treated: _____

5. What date did you first seek treatment for this injury? : _____
6. Have you ever had this same type of injury before? Yes No If yes, when and where did the injury occur and what was the name and address of the physician who treated you for that injury: _____

PART C... If this claim is the result of an illness, please answer the following questions (1 thru 7)

1. Was the MEDEX Assistance Center notified? Yes No If yes, when: _____
2. Date you first noticed the symptoms which led you to seek treatment: _____
3. Describe the illness or give the actual diagnosis of the illness: _____

4. Name and address of the physician or hospital where you were treated: _____

5. What date did you first seek treatment for this illness?: _____
6. Have you previously been treated for this illness or similar condition before? Yes No If yes, Please give the name and address of the physician who treated you and the approximate dates you were treated: _____

7. Name and address of primary physician who has treated you (for any illness) during the past year: _____

