

SELF INSURED SERVICES CO.

P.O. Box 389 * Dubuque, IA 52004-0389
(319) 583-7344

Employee's Statement (complete and answer all questions)

SECTION I.

Name of Employer: _____

- Active Employee
- Retired Employee

Employee Information

Name _____ Birthdate _____
First Middle Last
Address _____
Number Street City State Zip
Social Security Number -- -- Home Phone # _____

- Married Widowed
- Single Divorced
- Legally Separated Separated

Spouse's Information

Name _____ Birthdate _____
First Middle Last
Address _____
Number Street City State Zip
Social Security Number -- --
Employer _____
Employer's Address _____
Number Street City State Zip

- Full-Time Part-Time

SECTION II. – Patient Information

Patient's Name _____
Full Time Student _____ Date of Enrollment ____/____/____
 Yes No

- Male Employee
- Female Spouse
- Child

Patient's Birth Date
Social Security #

If a full-time student, name, address, and phone number of school:

If patient is employed, list name and address of patient's employer:

SECTION III. – Accident Information (if applicable)

Date of Accident _____

How did accident happen? _____

- Place of accident Home Work Other – give location and other pertinent information, i.e. address, name of property owner or responsible person

SECTION IV. – Other insurance Information

- Is patient covered by any other Plan? Yes No
 - Is other coverage available through spouse's employer? Yes No
 - No Fault Automobile Insurance as a result of injuries sustained in an automobile accident? Yes No
- If any of the above are answered "Yes" please indicate in "remarks" the policy number and the name, complete address and phone number of the other carrier.

Remarks

FOR SISCO USE ONLY

SECTION V.

I hereby certify that the above statements are correct

Employee's Signature _____

Assignment of Benefits:

I hereby authorize payment directly to the physician and/or hospital who provided services for which benefits are payable, but not to exceed the reasonable and customary charges.

Insured Person's Signature _____ Date: _____

Authorization to Release Information

I hereby authorize all physicians, hospitals, druggists, and all other agencies including other health plan administrators to furnish to Self Insured Services Co. (SISCO) or the employer full information pertaining to my medical care and expenses.

Patient's Signature (or parent, if patient is a minor) _____ Date of Birth _____

Attending Physician's Statement (This section need not be completed if an ITEMIZED Statement is attached)

Patient's full name _____ Date of Birth _____

1. Diagnosis and concurrent conditions (if diagnosis code other than ICDA* used, give name)

2. Is condition due to injury or sickness arising out of patient's employment? Yes No
 Yes No
 Pregnancy Yes No
 If yes, approximate date Pregnancy commenced. _____

3. Report of services (or enclosed itemized bill)

Date of Services	Place of Services [†]	Description of surgical or medical services rendered	Procedure Code – If used (if code other than CPT** used, give name)	Charges
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

[†] O – Doctor's Office	OH - Outpatient hospital	*ICDA – International Classification of Diseases	TOTAL CHARGES \$ _____
H – Patient's home	NH – Nursing home	**CPT – Current Procedural Terminology (current edition)	AMOUNT PAID \$ _____
IH – Inpatient hospital	OL – Other locations		BALANCE DUE \$ _____

4. Date symptoms first appeared or accident happened. _____ 5. Date patient first consulted you for this condition. _____

6. Patient ever had same or similar condition? Yes No
 7. Patient still under your care for this condition? Yes No

If yes, when and describe.

Physician's name (print) _____ Individual Health Care Practitioners – Enter your Social Security No.* _____ All Others – Enter Fed. I.D. No. _____

Signature _____ Degree _____ Telephone No. _____ Date _____

Address Street _____ City or Town _____ State _____ Zip _____