HOSPITAL SAFEGUARD PREMIER CLAIM FORM

Golden Rule Insurance Company
UnitedHealthcare Life Insurance Company

Instructions for Filing Your Claim:

1. Fill out this form completely. Failure to do so could result in a delay in processing this claim.
   NOTE: A separate claim form must be submitted for each patient.
2. Parts 1 & 2 are required to be submitted along with all supporting documents and itemized bills.

Mail or fax all forms and documents to: **Claims Department**
PO Box 31374
Salt Lake City, UT 84131-0374

Fax to: 1-801-478-7581

If there are any questions about what benefits are covered or how to use this form, please contact our customer service department at **1-800-657-8205**, or refer to your plan documents.

PART 1: PRIMARY INSURED & PATIENT INFORMATION

Primary Insured Name:		Policy Number:	
Address:	City:	State:	ZIP Code:
Daytime Phone Number:		Date of Birth:	

Patient Name:		Policy Number:	
Address:	City:	State:	ZIP Code:
Daytime Phone Number:		Date of Birth:	

PART 2: REASON FOR CLAIM — CHECK ALL APPROPRIATE BOXES

❑ Claim is for hospital. *Submit itemized bills.*

❑ Claim is for ambulance. *Submit itemized bills.*

❑ Claim is for urgent care. *Submit itemized bills.*

❑ Claim is for surgical services. *Submit itemized bills.*

❑ Claim is for accidental injury. *Submit itemized bills and a copy of the police report (if applicable).*
Date of Accident: ____/____/____ Description of Accident Details: ______________________________

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(Attach a separate sheet if necessary.)

Plans are underwritten by Golden Rule Insurance Company or UnitedHealthcare Life Insurance Company.
Administrative services are provided by United Healthcare Services, Inc. or their affiliates.
3100 AMS Blvd., PO Box 19032, Green Bay, WI 54307-9032, 1-800-232-5432.

I verify that all information contained in this form is true, correct, and complete to the best of my knowledge.

To process a claim for benefits, I authorize any health care provider or facility, pharmacy, government agency, insurance company, or benefit plan administrator having information as to the care, advice, treatment, or diagnosis of the patient named below, to provide any and all of this information to Golden Rule Insurance Company or UnitedHealthcare Life Insurance Company, or any agent or independent administrator acting on its behalf.

I understand that I have the right to receive a copy of this authorization upon request, and that I have the right to revoke any authorization by notifying Golden Rule Insurance Company or UnitedHealthcare Life Insurance Company in writing. I understand that revocation of or failure to sign an authorization may impair Golden Rule Insurance Company or UnitedHealthcare Life Insurance Company's ability to evaluate or process a claim, and may be the basis for denying claims for benefits.

A copy of this shall be as valid as the original. This authorization is valid for 12 months from the date signed.

Warning: 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 guilty of insurance fraud.

Warning: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Warning: For your protection Florida law requires the following statement to appear on this form. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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Name of Patient *(Please Print)*

X ____ ______________________________
Signature of Patient or Authorized Representative **Date**

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