



MEDICAL AND DENTAL EXPENSES

ELFUN MEDICAL BENEFITS PLAN



A UnitedHealth Group Company

CLAIM FORM

Also for: GE Medical Care Plan for Pensioners and GE Pensioners Hospital Indemnity Plan

Part 1 MEMBER INFORMATION Please show Member's name and Social Security Number even when applicant is a Qualified Dependent.

FIRST	MIDDLE	LAST	Social Security Number			
Name (Print)						
STREET		CITY	STATE	ZIP	CODE	Is this a new address since your last claim? <input type="checkbox"/> Yes <input type="checkbox"/> No
Present Address of Member or Qualified Dependent:						

Part 2 QUALIFIED DEPENDENT INFORMATION: Complete this section only if expenses are incurred by qualified dependent for ELFUN member.

FIRST	MIDDLE	LAST	Date of Birth		
Qualified Dependent's name (Print)			MO.	DAY	YR.

Is Qualified Dependent a retiree of GE? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, SS # _____	Is Qualified Dependent covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, see instruction #5 on other side.
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Part 3 TYPE OF CARE

<input type="checkbox"/> Medical see instructions 1 through 6 on the back of this form	<input type="checkbox"/> Dental see instruction 7 on the back of this form
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Part 4 ACCIDENT INFORMATION Complete this section only if claim is result of accidental injury.

Date of accident	Where did accident occur? City/State	Describe accident:
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Part 5 OTHER GROUP COVERAGE INFORMATION

Are any expenses included in this claim covered under another employer group or union welfare plan or program for any hospital, surgical, or other benefits or services? Yes No If "Yes," complete the following:

(a) Under such other plan or program does covered employee pay the full cost for both personal and dependent coverage? Yes No

(b) Name and address of company or organization (i.e. Employer, Union, Association, etc.) sponsoring the plan or program

(c) Name, address and phone number of provider of other group coverage _____

Part 6 MEDICAL AUTHORIZATION

I authorize any insurance company, organization, employer, hospital, physician, pharmacist to release any information requested with regard to this claim and the expenses reported. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.	SIGNED (Member or Qualified Dependent) (if other, indicate relationship below) _____ _____ DATE
	<input type="checkbox"/> Executor <input type="checkbox"/> Power of Attorney

Part 7 PAYMENT OF BENEFITS CHECK HERE IF YOU WANT PAYMENT TO GO DIRECTLY TO PROVIDER OF SERVICE. See instruction # 6 on other side.
 CHECK HERE IF PAYMENT IS TO BE MADE DIRECTLY TO YOU.

Mail completed form to:
GE Medicare Benefit Plans Claims Center
P.O. Box 740822
Atlanta, GA 30374

For claim inquiries please call:
1-800-848-8406
 8:00 AM to 5:00 PM (Eastern Time)

INSTRUCTIONS FOR FILING A CLAIM:

The member or Qualified Dependent (spouse, surviving spouse, same sex domestic partner) must answer all questions and sign in the space provided. A separate claim form must be completed for each patient. If the member or Qualified Dependent cannot sign this form, the signee should indicate the relationship and attach power of attorney or estate papers where appropriate.

TO AVOID DELAY, BE SURE THE FOLLOWING ARE ATTACHED:

(please securely staple to form)

1. If your claim is for an inpatient hospitalization, submit the Medicare Explanation of Benefit Statement and a UB92/UB82 or a HCFA 1500.
2. If your claim is for outpatient surgery performed in an approved ambulatory surgical facility or outpatient department of a hospital, attach an itemized bill showing the date of service, the charge for the use of the facility and a copy of the Explanation of Benefits form from the provider of Medicare benefits in your area.
3. If your claim is for a confinement in an extended care facility, submit a monthly interim bill from the facility and the Medicare Explanation of Benefit Statement. This bill must be signed by an authorized representative facility.
4. Attach a copy of the explanation of benefits form from the provider of Medicare benefits in your area.
5. If you incur covered medical expenses not reimbursed by Medicare such as services of a registered nurse, or medical expenses incurred due to travel outside the U.S., or if not eligible for Medicare because of age, attach bills itemizing these expenses. Each bill should contain a complete description of the service rendered, a diagnostic code, the date of charge, and the name and address of the provider rendering the service.
6. If benefits are to be paid directly to the provider(s), please make sure to mark the appropriate box in Part 7. You must also attach a copy of the provider's bill which includes provider's name, address, telephone number and tax ID number.
7. The Elfun Medical Benefits Plan provides coverage for preventive dental services. Benefits are limited to two oral exams, two dental cleanings and one x-ray per calendar year. When filing claims, please have your provider complete the section below or attach an itemized bill from your provider.

	For Internal Use Only		Charge	Date of Service	Dentist Name
	Exam	DENT			Address
Exam	OF	DENT			Address
Cleaning	OL	DENT			City, State and Zip
X-ray	FS	DENT			Phone Number
Dentist Signature					Tax ID Number
					License Number