Student Health Insurance Claim form

For the Accident, Injury Claim. – Fall accident, Motor vehicle or, else

You must submit all claim documents to our claim's administrator, Five Points, within **90 days** from the date of service. The insurance company maintains its right to investigate, request additional information, and verify eligibility or other terms for claims processing.

Member Name (First Name Last Name):	Member Insurance ID:
Member Date of Birth (MM/DD/YYYY):	Member Current Address (address, City, State, Zip code)
Member Mobile Phone Number:	Member Email Address:
Bank Account Holder Name:	What is the bank account? ☐ Checking. ☐ Saving
Checking/Savings Account Routing # -9 Digits (Only US bank)	Checking/Savings Account # 6-13 Digits (Only US bank)

Please Check and input below questions:

1) Are you submitting a claim for you ☐ YES (move to #2) ☐ NO
   Dependent's Name: _____ Dependent's Date of Birth (MM/DD/YYYY): _____
2) Did you pay for this claim already? ☐ YES ☐ NO
3) When did you have an accident/injury (MM/DD/YYYY with Time): _____
4) Have you ever received treatment for this Injury from other insurance policy ☐ YES ☐ NO
5) Have you ever received treatment for this symptom or sickness ☐ YES ☐ NO
6) Is this Injury related to auto accident? ☐ YES ☐ NO
7) Did you have this Injury while you are working? ☐ YES ☐ NO
8) Is there Third Party be responsible to this injury/accident ? ☐ YES ☐ NO
9) Is this Injury related to sports? If yes, select ☐ Recreational ☐ Club ☐ Intramural ☐ Intercollegiate
10) How did you get this Injury or accident(In detail): _____

    _____

11) What part of your body was injured:_____
12) Where did you receive the treatment? ☐ Student Health Center ☐ Urgent Care ☐ Out-of Network office ☐ ER

- For email submitting, Save this form and attaches the receipts and related slips and email to claims@fivepointsmecplan.com
- For mail submitting, if you submit a claim via post mail. Mail to below address with this form, receipts/slips
  Address: 6006 N Mesa St.Ste 108 Coronado Tower, El Paso, TX 79912

I authorize any physician, hospital, company, employer or organization to release the medical history, treatments or benefits **payable** for this claim to Five Points Benefit Plan, LLC or its payor for which it is an authorized plan administrator. A photocopy of this form shall be just as valid as the original. I authorize Five Points Benefit Plan, LLC or its representatives to pay all bills in conjunction with this claim directly to the physician, hospital or other health care provider rendering service.

I certify that I have read all answers to this form, and to the best of my knowledge the information I have given is complete and true. Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty (not to exceed five thousand dollars in Texas) and the stated value of the claim for each violation.

Signature of Claimant: _____Date (MM/DD/YYYY): _____

Direct Deposit Authorization Form For Insurance Claim Payments

Automatic Direct Deposit is a convenient feature for members to receive their claim payment(s). If you decide to take advantage of Automatic Direct Deposit, your approved claim(s) will be deposited automatically into the U.S. bank checking or savings account you provide. By completing the Authorization Form below and providing a copy of a voided check or savings deposit slip, you are authorizing Five Points Benefit Plan, LLC and your financial institution to deposit your insurance payment(s) into your checking or savings account.

*This form only needs to be submitted with the first payment. All subsequent payments for the indicated coverage will automatically be processed via ACH until Five Points Benefit Plan, LLC is notified in writing of a requested change. Change requests should be sent to claims@fivepointsmecplan.com.

I hereby authorize Five Points Benefit Plan, LLC to deposit insurance payment(s) directly into my checking or savings account indicated above. I also authorize my financial institution accept my deposit(s) and to credit the amount to my account.

Please attach this completed form and a copy of a voided check or savings deposit slip to your completed insurance claim form.

I understand that this authorization will remain in full force and effect for the coverage indicated above until I notify Five Points Benefit Plan, LLC in writing that I wish to revoke this authorization. I understand that Five Points Benefit Plan, LLC requires at least 7 days prior notice of my next payment in order to cancel this authorization.

Signature _____ Date _____

Complete this form, sign up then upload related attachments for the complete claim submission.

If you itemize the bills and slips, your claim will be handled early.

CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA: 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.

ALASKA and KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA: WARNING :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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TENNESSEE and VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.