Claim No. ________________

Any person who, with intent to defraud or knowing that he is facilitating a fraud against and insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Lodge Secretary Address

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SICK BENEFIT CLAIM

Name______________________________Lodge No.________City________________________State________

Last 4 Digits of Social Security No.___ ___ ___ ___ Rating age________Plan and Cert. No.____________________

Member's complete address____

Date reported ill:______________________________Sick benefit at $________________per day – per week

Dated this________day of____________________20______ ______________________________

Lodge Secretary

AUTHORIZATION

I hereby authorize the hospital or physician who has attended me, to release any and all information regarding my illness or accident.

Date________________________Signed____(Claimant)

MEDICAL REPORT

NOTE: Signed Standard Insurance Claim forms, giving necessary information, are acceptable in lieu of this form. Please attach to this form.

Claimant's name:____Age __________

Diagnosis: ____

Date physician first consulted for this illness: ____

Hospitalized at________________________Hospital; from____________________to ____________________

Name of operation, if any:____Date ____________________

Period of TOTAL disability for claimant. . . from________________________to ________________________

Remarks: ____

Signed:__________________________________M.D. Graduate of: ______________________________

Complete address:____Date __________________

(Note to Physician – Return claim to claimant or Lodge Secretary)

APPROVED REJECTED for payment from________________________to ______________________

Remarks ____

Date________________________ ____________________________________Medical Consultant

Form SBC 06.2018