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.

Claim No. ________________

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_____

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)

APPROVED REJECTED for payment from_________________________to _______________________

Remarks ____

Date___________________________ ____Medical Consultant

Form SBC 03.2020