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FAX: 417-883-8261

Cooper County
Employee Dependent Claim Form

⇒ PART I COMPLETE FOR ALL CLAIMS (TO BE COMPLETED BY EMPLOYEE ONLY)

Employee's Name:____

Social Security#:____ Date of Birth: _________________

Home Address: ____
(Number) (Street/Apt#) (City) (State) (Zip)

⇒ PART II COMPLETE FOR DEPENDENT CLAIM ONLY

Dependent's Name: ___________________________________ Date of Birth: ___________ ☐Male ☐Female

Relationship: ☐Spouse ☐Son ☐Daughter ☐Other: ____

⇒ PART III COMPLETE FOR ALL CLAIMS

If you or your dependents were covered by another health plan, insurance carrier or government sponsored health plan prior to this coverage, please provide us with a copy of your Certificate of Creditable Coverage from the previous Carrier.

Is the person for whom claim is made covered under any other Group Health Plan or Medicare? ☐Yes ☐No

Insured Member's Name: _____________________________________ Social Security# _________________________

Name of other Insurance Co.:_____________________________ Group/Contract Number: ___________________________

Address: ____ Telephone Number: (___) - __________Ext:_____
(Number/Street) (City) (State) (Zip)

⇒ PART IV COMPLETE FOR ACCIDENT CLAIMS

Date of Accident: _________ Was the patient at work when the accident happened? ☐Yes ☐No Auto Accident? ☐Yes ☐No

Describe where and how the accident happened:

____

____

Is a third party insurance company responsible (e.g. automobile insurance, home owners etc.)? ☐Yes ☐No
(If yes, please provide name of insurance company, address, phone number and group or contract # on the back of this form).

⇒ PART V COMPLETE FOR SICKNESS CLAIMS

Nature of Sickness: _____________________________________Was patient at work when sickness began? ☐Yes ☐No

Will you or your dependent be filing for Worker's Compensation? ☐Yes ☐No

I/We certify that the above information is true and correct. I/We authorize the release of any medical or other information necessary to evaluate and complete the review and processing of any claims for reimbursement. A photocopy of this authorization shall be considered as valid as the original.

Signature of Employee: ________________________**Signature of Spouse**: ______________________ **Date**: ____________
(if patient)