



Administrated by:
 Employer Plan Services, Inc.
 2180 N. Loop West, Suite 400
 Houston, TX 77018
 Customer Service Number for Claims –
 800-447-6588
 Fax Number for Claims - 713-973-8920

WELLNESS BENEFIT CLAIM FORM

(BENEFITS MAY BE DELAYED IF CLAIM FORM IS NOT FULLY COMPLETED)

Please submit the following information with the completed claim form:

The type of health screening that was performed, date of service and copy of bill

If you were treated at a non-cost incurred facility, please furnish verification from the facility and the date/type of tests performed.

1. Name (First, Middle, Last)			
2. Social Security Number			
3. Birthdate (mm/dd/yyyy)			
4. Address (Street or Apt#)			
City	State	Zip Code	Home Phone (including area code)
5. E-Mail Address			

6. Type of test(s) performed:	Date Test Performed (mm/dd/yyyy)
7. Doctor's Name	Doctor's Phone and Fax Number
8. Doctor's Address (Street, City, State & Zip Code)	

Certification

Name

Social Security Number

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I acknowledge that I have received the 'Claim From Addendum, Fraud Warning and State Versions' form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form.

Date (mm/dd/yyyy)	Signature
_____	_____