LeadersLife INSURANCE COMPANY

Group Accident Claim Form
Outpatient Physician Expense Benefit

Please complete this form in full. If you have any questions, please contact our Claims Department. Claims can be mailed, faxed or emailed to the address, fax or email listed below.

CERTIFICATE HOLDER INFORMATION

Full Name of Policy Holder _____ Date of Birth _____

Certificate Number _____ Social Security Number _____

Phone Number _____ Email Address _____

Street Address _____ City _____ State _____ Zip _____

CLAIMANT INFORMATION (If different)

Full Name of Claimant _____ Date of Birth _____

Relationship of Claimant to Certificate Holder _____ Social Security Number _____

OUTPATIENT PHYSICIAN EXPENSE BENEFITS DETAILS - Please provide the reqeusted informaton below or an EOB, with date of service and reason for visit.

Name of Physician _____ Physician Phone Number _____

Street Address _____ City _____ State _____ Zip _____

Date of Visit _____ Reason for Visit _____

I represent that all statements and answers in this claim form are complete, true and correctly recorded to the best of my knowledge and belief and that I have appropriate knowledge to answer the questions for my spouse and children.

Signed at (city) _____ State _____ this _____ Day of _____ 20_____

Signature of Claimant _____ Owner (if other than Claimant)) _____