

**KLAIS & COMPANY, INC.**  
**Medical and Prescription Drug Claims Form**

**Student Information**

Student Name \_\_\_\_\_ Student ID Number: \_\_\_\_\_

(School) Student Street Address \_\_\_\_\_  
Last First Middle Initial

(School) City, State & Zip \_\_\_\_\_

(Home) Student Street Address \_\_\_\_\_

(Home) City, State & Zip \_\_\_\_\_

Claim is for  Student  Student's Spouse  Student's Child \_\_\_\_\_

Is patient covered for benefits (other than this policy) by any Group Health Benefits or any Federal, State or other Government Agency Plan? If yes, please complete the following:  
Through whom was your coverage provided? (i.e. parent, spouse, etc.) \_\_\_\_\_

Insurance Company Benefit Plan \_\_\_\_\_ Plan/Group Number \_\_\_\_\_  
Name Relationship

Insurance Company Address \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Is this claim the result of an accident?  Yes  No If yes, give date of accident (MM/DD/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE STAPLE ALL PRESCRIPTION DRUG AND/OR MEDICAL RECEIPTS TO THIS FORM.**

**Student Authorization**

PLEASE READ AND SIGN I certify, under penalty of perjury, that all information provided on this form is true to the best of my knowledge. I certify that all attached receipts are for prescription drugs and/or medical services obtained for myself and/or dependents. I hereby authorize any physician, hospital, insurance company, employer or organization to release any information regarding the medical history, treatment or benefits payable for this claim.

Student's Signature X \_\_\_\_\_ Date (MM/DD/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_

**Klais & Company, Inc.** 1867 West Market Street • Akron, OH 44313-6977 • Telephone: (800) 331-1096 • Fax: (330) 867-0827

**KLAIS & COMPANY, INC.**  
**Medical and Prescription Drug Claims Form**

**Student Information**

Student Name \_\_\_\_\_ Student ID Number: \_\_\_\_\_

(School) Student Street Address \_\_\_\_\_  
Last First Middle Initial

(School) City, State & Zip \_\_\_\_\_

(Home) Student Street Address \_\_\_\_\_

(Home) City, State & Zip \_\_\_\_\_

Claim is for  Student  Student's Spouse  Student's Child \_\_\_\_\_

Is patient covered for benefits (other than this policy) by any Group Health Benefits or any Federal, State or other Government Agency Plan? If yes, please complete the following:  
Through whom was your coverage provided? (i.e. parent, spouse, etc.) \_\_\_\_\_

Insurance Company Benefit Plan \_\_\_\_\_ Plan/Group Number \_\_\_\_\_  
Name Relationship

Insurance Company Address \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Is this claim the result of an accident?  Yes  No If yes, give date of accident (MM/DD/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE STAPLE ALL PRESCRIPTION DRUG AND/OR MEDICAL RECEIPTS TO THIS FORM.**

**Student Authorization**

PLEASE READ AND SIGN I certify, under penalty of perjury, that all information provided on this form is true to the best of my knowledge. I certify that all attached receipts are for prescription drugs and/or medical services obtained for myself and/or dependents. I hereby authorize any physician, hospital, insurance company, employer or organization to release any information regarding the medical history, treatment or benefits payable for this claim.

Student's Signature X \_\_\_\_\_ Date (MM/DD/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_

**Klais & Company, Inc.** 1867 West Market Street • Akron, OH 44313-6977 • Telephone: (800) 331-1096 • Fax: (330) 867-0827