



# AMERCO BASIC COVERAGE CLAIM FORM

2721 NORTH CENTRAL AVE., PHOENIX, ARIZONA 85004-1172 • (888) 757-3732

- A) COMPLETE CLAIM FORM;
- B) ATTACH ALL BILLS;
- C) SEND TO OXFORD LIFE INSURANCE CO. AT THE ADDRESS BELOW.

## STATEMENT OF SYSTEM MEMBER (YOUR CAREFUL ATTENTION TO ALL OF THE QUESTIONS WILL EXPEDITE PAYMENT OF YOUR CLAIM)

|                      |                     |               |
|----------------------|---------------------|---------------|
| SYSTEM MEMBER'S NAME | SOCIAL SECURITY NO. | DATE OF BIRTH |
|----------------------|---------------------|---------------|

|                |                       |
|----------------|-----------------------|
| STREET ADDRESS | CITY, STATE, ZIP CODE |
|----------------|-----------------------|

|                  |                  |              |  |              |
|------------------|------------------|--------------|--|--------------|
| PHONE NO.<br>( ) | COMPANY/DEPT NO. | DATE OF HIRE | HAS EMPLOYMENT TERMINATED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO | IF YES, DATE |
|------------------|------------------|--------------|--|--------------|

|   |                             |                              |                   |                        |  |
|---|-----------------------------|------------------------------|-------------------|------------------------|--|
| <input type="checkbox"/> <b>MARRIED</b> →<br>(COMPLETE 3 LINES AT RIGHT)<br><br><input type="checkbox"/> <b>SINGLE</b><br>(INCLUDES DIVORCED, WIDOWED, SEPARATED) | NAME OF SPOUSE              | SPOUSE'S SOCIAL SECURITY NO. | DATE OF MARRIAGE  | SPOUSE'S DATE OF BIRTH |  |
|   | SPOUSE'S OCCUPATION         |                              | SPOUSE'S EMPLOYER |                        |  |
|   | SPOUSE'S EMPLOYER'S ADDRESS |                              |                   | PHONE NO.<br>( )       |  |

|  |   |                         |
|--|---|-------------------------|
| PATIENT'S NAME (IF OTHER THAN SYSTEM MEMBER) | RELATIONSHIP TO SYSTEM MEMBER<br><input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER | PATIENT'S DATE OF BIRTH |
|--|---|-------------------------|

PATIENT'S OCCUPATION \_\_\_\_\_

|   |                       |
|---|-----------------------|
| IF PATIENT IS A STUDENT AGE 19 OR OLDER, GIVE NAME OF ACCREDITED SCHOOL PATIENT IS ATTENDING: | NO. OF SEMESTER HOURS |
|---|-----------------------|

|                              |                       |
|------------------------------|-----------------------|
| ADDRESS OF ACCREDITED SCHOOL | CITY, STATE, ZIP CODE |
|------------------------------|-----------------------|

|                   |   |                      |   |  |
|-------------------|---|----------------------|---|--|
| TYPE OF CONDITION | <input type="checkbox"/> <b>ILLNESS</b><br><input type="checkbox"/> <b>INJURY</b> | DATE CONDITION BEGAN | IF INJURY, DID INJURY RESULT FROM EMPLOYMENT?<br><input type="checkbox"/> YES <input type="checkbox"/> NO | IF YES, DO NOT USE THIS FORM. REPORT ACCIDENT TO SUPERVISOR. HE/SHE WILL COMPLETE PROPER FORM. |
|-------------------|---|----------------------|---|--|

IF INJURY, DESCRIBE ACCIDENT IN DETAIL (HOW, WHERE, WHEN, ETC.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### AUTHORIZATION

These statements are true and complete to the best of my knowledge. The knowing falsification of information on this claim form constitutes a felony punishable by fine or imprisonment (18 U.S.C. Section 1027). Any person who knowingly and with intent to injure, defraud or deceive any insurance company or any other person files a claim containing any false, incomplete or misleading information is guilty of a crime. Penalties may include imprisonment, fines and denial of insurance benefits. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company or other organization, institution or person that has any record or knowledge of my, or my dependent's, health or insurance coverage, to give the Oxford Life Insurance Company any information deemed necessary by Oxford to determine the validity or amount payable on account of this claim. I understand that I am financially responsible for the charges not covered by Oxford.

Signature of System member: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date \_\_\_\_\_  
(if 15 years of age or older)

**AUTHORIZATION TO PAY:** I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services. I understand that I am financially responsible for the charges not covered by this authorization.

Signature of System member: \_\_\_\_\_ Date \_\_\_\_\_

### ATTENDING PHYSICIAN: COMPLETE THIS SECTION

|  |      |                  |
|--|------|------------------|
| ATTENDING PHYSICIAN'S SIGNATURE:<br><b>X</b> | DATE | PHONE NO.<br>( ) |
|--|------|------------------|

|   |                                       |
|---|---------------------------------------|
| PRINT OR TYPE PHYSICIAN'S NAME AND DEGREE | SOCIAL SECURITY OR TAX PAYOR I.D. NO. |
|---|---------------------------------------|

|                |                       |
|----------------|-----------------------|
| STREET ADDRESS | CITY, STATE, ZIP CODE |
|----------------|-----------------------|