

AMERCO

MEDICAL PLAN

GROUP MEDICAL EXPENSE CLAIM

(NON-OCCUPATIONAL ONLY)

Administered By OXFORD LIFE INSURANCE CO. 2721 NORTH CENTRAL AVE., PHOENIX, ARIZONA 85004-1172 • (888) 757-3732

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

NAME		DATE HIRED	SOCIAL SECURITY NUMBER	(AREA CODE) TELEPHONE NUMBER	
ADDRESS		CITY, STATE, ZIP CODE			
<input type="checkbox"/> MARRIED → <small>(COMPLETE 3 LINES AT RIGHT)</small>	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		(AREA CODE) TELEPHONE NUMBER		
<input type="checkbox"/> SINGLE <small>(INCLUDES DIVORCED, WIDOWED, SEPARATED)</small>					
NAME OF PATIENT		RELATIONSHIP TO SYSTEM MEMBER: <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:			
TYPE OF CONDITION	<input type="checkbox"/> ILLNESS <input type="checkbox"/> INJURY	DID CONDITION RESULT FROM EMPLOYMENT? <input type="checkbox"/> NO <input type="checkbox"/> YES <small>IF YES, DO NOT USE THIS FORM. REPORT ACCIDENT TO SUPERVISOR. HE/SHE WILL COMPLETE PROPER FORM.</small>	ADDRESS OF ACCREDITED SCHOOL	NO. OF SEMESTER HOURS	
IF INJURY, DESCRIBE ACCIDENT IN DETAIL (HOW, WHERE, WHEN, ETC.)					

DO YOU FEEL ANOTHER PARTY IS RESPONSIBLE FOR THIS INJURY OR ILLNESS? YES NO IF YES, EXPLAIN:

PATIENT'S DOCTOR(S) FOR PAST YEAR	CONDITION(S)	DATES(S) CONSULTED

IS PATIENT COVERED BY ANY OTHER GROUP POLICY OR PLAN? NO YES — IF YES, COMPLETE NEXT 3 LINES:

NAME OF INSURANCE COMPANY OR PLAN		(AREA CODE) TELEPHONE NUMBER
NAME OF INSURED	POLICY AND/OR CERTIFICATE NUMBER	
ADDRESS OF INSURANCE OFFICE WHERE CLAIMS ARE PAID		

IMPORTANT:

PHYSICIAN'S STATEMENT ON REVERSE SIDE **MUST** BE COMPLETED BEFORE RETURNING, UNLESS BILLS DETAIL TREATMENT AND DIAGNOSIS OR MEDICATION, OR A SEPARATE PHYSICIAN'S STATEMENT IS ATTACHED. **DO NOT PRESENT CANCELLED CHECKS OR CASH RECEIPTS.** THEY DO NOT CONTAIN THE INFORMATION NEEDED TO PROCESS A CLAIM.

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.

Signature of System Member: _____ Date: _____

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

IF YOU WANT PAYMENT TO GO DIRECTLY TO PHYSICIAN OR HOSPITAL, PLEASE SIGN THE "AUTHORIZATION TO PAY" STATEMENT ON THE REVERSE SIDE.

AMERCO MEDICAL PLAN

ATTENDING PHYSICIAN'S STATEMENT HEALTH INSURANCE CLAIM

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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 as described below. I understand that I am financially responsible for the charges not covered by this authorization.

Signature of System Member: _____ Date: _____

PATIENT'S NAME	DATE OF BIRTH
PATIENT'S ADDRESS	CITY, STATE, ZIP CODE

DIAGNOSIS AND CONCURRENT CONDITIONS

ICD. 9 CODE	
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IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DO NOT USE THIS FORM. USE THE INDUSTRIAL ACCIDENT FORM.				
IS INJURY OR SICKNESS DUE TO AN INTENTIONALLY SELF-INFLICTED CONDITION?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, GIVE DETAILS:				
IS INJURY OR SICKNESS DUE TO AN ACT OR OMISSION OF A THIRD PARTY?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, EXPLAIN:				
IS CONDITION DUE TO PREGNANCY?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT WAS THE APPROXIMATE DATE OF COMMENCEMENT OF PREGNANCY: _____ DATE: _____				
WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?	DATE: _____	WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?	DATE: _____	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? (IF NO, GIVE DATE YOUR SERVICES TERMINATED)	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE: _____
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION BEFORE?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, STATE WHEN AND DESCRIBE:				
REFERRING PHYSICIAN	ADDRESS:					

NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE (DESCRIBE FULLY)

DATE PERFORMED	CHARGE TO THE PATIENT FOR THIS PROCEDURE, INCLUDING POST-OPERATIVE CARE: \$ _____	WERE REGISTERED PRIVATE DUTY NURSE (R.N.) SERVICES NECESSARY?	<input type="checkbox"/> YES <input type="checkbox"/> NO	WAS PROCEDURE PERFORMED IN A HOSPITAL? (IF YES, COMPLETE NEXT LINE)	<input type="checkbox"/> YES <input type="checkbox"/> NO
NAME OF HOSPITAL	ON WHAT BASIS WAS PATIENT TREATED? <input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT				

OTHER MEDICAL (NON-SURGICAL) TREATMENT, IF ANY:

WHERE TREATED (OFFICE, HOSPITAL, OTHER)	DATE TREATED	SERVICES RENDERED	AMOUNT CHARGED
			\$
			\$
			\$
			\$

HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED—I.E. UNABLE TO WORK? (IF EXACT LENGTH OF TIME CANNOT BE DETERMINED, PLEASE ESTIMATE)	IF HOUSE CONFINEMENT WAS OR WILL BE NECESSARY, GIVE DATES:
FROM: _____ THRU: _____	FROM: _____ THRU: _____

TO YOUR KNOWLEDGE, IS PATIENT COVERED BY ANY OTHER HEALTH INSURANCE OR PLAN?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, IDENTIFY:
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DATE	ATTENDING PHYSICIAN'S SIGNATURE:	PHONE NO.
PRINT OR TYPE PHYSICIAN'S NAME AND DEGREE	SOCIAL SECURITY OR TAX PAYOR I.D. NO.	
STREET ADDRESS	CITY, STATE, ZIP CODE	