SIS

CLAIM VERIFICATION FORM

Policyholder Name: _____

Policy #: _____

Policy Term: _____ to _____

Dear Policyholder:

The attached or previously issued policy contains accident medical coverage. To allow claim processing, we require that a representative and alternate representative of the Policyholder be named in the spaces provided below to verify all claims. These representatives must verify, by signature, the validity of all claims under this policy.

Upon completion of this form, please return it to Special Insurance Services, Inc. at the address listed below. This form must be returned to guarantee claim processing.

REPRESENTATIVE:		ALTERNATIVE REPRESENTATIVE:	
Name:	_____	Name:	_____
Title:	_____	Title:	_____
Phone #:	_____	Phone #:	_____
Date:	_____	Date:	_____
Signature:	_____	Signature:	_____

AUTHORIZED BY:

Name: _____

Title: _____

Phone #: _____

Date: _____

Signature: _____

SPECIAL INSURANCE SERVICES, INC.

P.O. Box 250349 • Plano, Texas 75025-0349 • (972) 788-0699 or (800) 767-6811