Print Form
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Email Form

**BENEFICIAL ADJUSTING CO.**
**ALPHA INSURERS BLDG.**
**123 ARCHBISHOP FLORES ST.**
**HAGATNA, GUAM 96910**
**(671) 477-1568/9**

# CLAIM FOR BODILY INJURY

**Notice to Claimant: In order that your claim for BODILY INJURY may receive proper consideration, you are requested to supply the information called for on this form. All relevant and material facts should be stated, as this will be the basis of further action upon your claim.**

| 1. Full Name of Claimant: | 2. Age: | 3. Occupation/Rank: |
|---|---|---|

| 4. Mailing Address: | 5. Street Address: | 6. Phone #: |
|---|---|---|

| 7. Date/Time of Accident: | 8. Location of Accident: |
|---|---|

9. Claim Against (Name, Address, Description of Vehicle He/She is Operating):

10. Description of Accident: (set forth all relevant and material details; if necessary, use opposite of diagram)

11. Offer of Settlement - I, hereby, offer to accept as full satisfaction of my claim the amount of $_____. To support my claim, I have attached the following documents (may include Police Report, Statements of Witness(es), and Medical Bills):

12. Nature of Injury:

| 13. Attending Physician: | 14. Physician's Address and Phone No.: |
|---|---|

15. Witness(es): (Please include Name, Address, and Phone No.)

16. Declaration - I certify that all of the statements set forth on this form are true to the best of my recollection and knowledge. All relevant and material facts have been stated.

**Executed this _____ day of _____, 20____, at _____.**

_____
**CLAIMANT'S SIGNATURE**

Print Form

# Beneficial Adjusting Co.

## AUTHORIZATION TO RELEASE MEDICAL RECORDS, BILLING & INFORMATION

**TO:** All Treating Physicians and Medical Facilities

**FROM:** Beneficial Adjusting Company

**RE:** Name: _____

Employer: _____

Occupation: _____

Social Security #: _____ Date of Birth: _____

This is to authorize any physician, hospital, clinic, nurse, medical attendant/coder/biller, etcetera or others to furnish to the **BENEFICIAL ADJUSTING COMPANY and CHUNG KUO INSURANCE COMPANY, LTD.,** or any representative thereof, access to and/or copies of any and all medical records, information or opinions regarding my physical condition and treatment for:

*** POTENTIAL AUTO RELATED BODILY INJURY OR MP ***

**from 2000 to the present** and to allow them to see or to copy any medical records, scans, prescriptions, test/lab results, medical work excuses/releases, etcetera which you/your medical facility may have regarding the above mentioned condition or treatment thereof.

**Your full cooperation with the Beneficial Adjusting Company and with Chung Kuo Insurance Company, Ltd. is requested. Please furnish copies of these reports to the Beneficial Adjusting Company office via fax at (671) 477-1570, via email at: _____ or they can be sent or delivered to us at: Alpha Insurers Building 1st Floor, 123 Archbishop Flores Street, Hagatna, Guam 96910, USA.**

A photocopy or facsimile copy of this authorization shall be as effective as its original.

_____
Claimant's Signature

_____ _____
Claimant's Printed Name Date

Alpha Insurers Bldg., 1st Floor, 123 Archbishop Flores St., Hagatna, GU 96910 | Tel: (671) 477-1568/9 | Fax: (671) 477-1570
www.alphainsurers.com | claims@alphainsurers.com

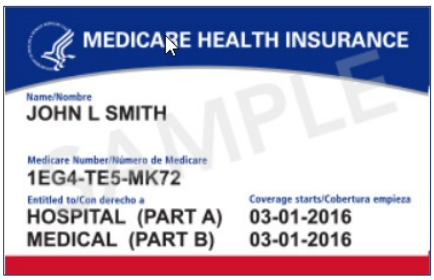
Dededo Branch: In A-One Store Bldg., Next to American Grocery | Tel: (671) 637-8833/44 | Fax: (671) 637-8855
General Agent for Chung Kuo insurance Co., Ltd.

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other private group health plan (GHP) insurance in addition to their Medicare benefits. There are federal rules that determine whether Medicare or the other GHP insurance pays first.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage. This reporting is to assist CMS and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

**Please review this picture of the Medicare card to determine if you, a spouse, or other family members covered by your group health plan have, or has ever had, a similar Medicare card.**




## Section I

| | | |
|---|---|---|
| Are you presently, or have you ever been, enrolled in Medicare Part A or Part B? | ☐ Yes | ☐ No |
| *If yes, please complete the following. If no, proceed to Section II.* | | |
| **Full Name:** *(Please print the name exactly as it appears on your SSN or Medicare card if available.)* | | |
| | | |
| **Medicare Number:** | **Date of Birth (Mo/Day/Year)** | |
| ****Social Security Number:** *(If Medicare Number is Unavailable)* | **Sex** ☐ Female | ☐ Male |

** Note: If you are uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last 5 digits of your SSN in the section above.

## Section II

| | | | |
|---|---|---|---|
| Do you have a spouse that is presently, or has ever been, enrolled in Medicare Part A or Part B? | | □ Yes | □ No |
| *If yes, please complete the following. If no, proceed to Section III.* | | | |
| **Full Name:** *(Please print the name exactly as it appears on their SSN or Medicare card if available.)* | | | |
| **Medicare Number:** | **Date of Birth (Mo/Day/Year)** | | |
| ****Social Security Number:** *(If Medicare Number is Unavailable)* | **Sex** | □ Female | □ Male |

## Section III

| | | | |
|---|---|---|---|
| Do you have another covered family member that is presently, or has ever been, enrolled in Medicare Part A or Part B? | | □ Yes | □ No |
| *If yes, please complete the following. If no, proceed to Section IV. If additional space is needed for completion of this section, please attach another sheet.* | | | |
| **Full Name:** *(Please print the name exactly as it appears on their SSN or Medicare card if available.)* | | | |
| **Relationship** *(Dependent child, domestic partner, etc.):* | | | |
| **Medicare Number:** | **Date of Birth (Mo/Day/Year)** | | |
| ****Social Security Number:** *(If Medicare Number is Unavailable)* | **Sex** | □ Female | □ Male |

| | | | |
|---|---|---|---|
| **Full Name:** *(Please print the name exactly as it appears on their SSN or Medicare card if available.)* | | | |
| **Relationship** *(Dependent child, domestic partner, etc.):* | | | |
| **Medicare Number:** | **Date of Birth (Mo/Day/Year)** | | |
| ****Social Security Number:** *(If Medicare Number is Unavailable)* | **Sex** | □ Female | □ Male |

| | | | |
|---|---|---|---|
| **Full Name:** *(Please print the name exactly as it appears on their SSN or Medicare card if available.)* | | | |
| **Relationship** *(Dependent child, domestic partner, etc.):* | | | |
| **Medicare Number:** | **Date of Birth (Mo/Day/Year)** | | |
| ****Social Security Number:** *(If Medicare Number is Unavailable)* | **Sex** | □ Female | □ Male |

## Section IV

I understand that the information requested is to assist my insurer, third-party administrator or group health plan to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

_____ _____

**Subscriber Name (Please Print)** **Subscriber's Plan ID**

_____

**Name of Person Completing This Form (Please Print)**

_____ _____

**Signature of Person Completing This Form** **Date**

*If you have completed Sections I – IV above, stop here. If you are refusing to provide the information requested in Sections I – IV, proceed to Section V.*

## Section V

_____ _____

**Subscriber Name (Please Print)** **Subscriber's Plan ID**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

**Reason(s) for Refusal to Provide Requested Information:**

_____

_____

_____

_____

_____ _____

**Signature of Person Completing This Form** **Date**