THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Risk Management Department
75 North Pace Blvd.
Pensacola, FL 32505
Phone: (850) 469-6156 Fax: (850) 469-6293

Application/Statement of Claim for Hospital Indemnity Plan

INSTRUCTIONS: To Be Completed By the Employee. Complete Application/Statement of Claim and attach hospital bills and/or admission/discharge documentation to support the dates and times of hospitalization. All claims are required to be filed with the Risk Management and Benefits Department within 90 days from your date of discharge to be eligible for consideration.

1. Your name (*Print*): _____ Phone: _____

2. Present address: _____
Street City State Zip Code

☐ Male ☐ Female Date of Birth: _____ ☐ Single ☐ Married Social Security No. | | | | | | | | | |

3. If you were hospitalized, as a bed patient, please answer the following:

(a) Name and address of hospital: _____

_____

(b) Date admitted: _____ ,20 _____ at _____ { a.m. p.m.

(c) Date discharged: _____ ,20 _____ at _____ { a.m. p.m.

4. Give any information which might assist Risk Management in the consideration of this claim:

_____

_____

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_____

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_____

I authorize any insurance company, organization, employer, hospital, physician, surgeon or pharmacist to release any information requested with respect to this claim and the attached bills.

I certify that the information I furnished to support this claim is true and correct. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signed (*Insured Employee)* _____

Date: _____ ,20 _____