PREMIER INSURANCE GROUP

Excellence in Coverage • Trusted Since 1985

TXN00000007

24/7 Helpline: 1-800-555-CLAIM | claims@premierinsurance.com

HEALTH INSURANCE CLAIM

Claim Date: May 13, 2020

■ TRANSACTION INFORMATION

Transaction ID	Transaction Date	Agent ID
TXN00000007	June 01, 2020 at 12:00 AM	AGENT00322

Vendor ID	Policy Effective Date
VNDR00150	October 26, 2012

■ POLICYHOLDER COMPLETE INFORMATION

Policy Number	Customer ID	Insurance Type
PLC00002796	A00007245	Health

Customer Name
Dennis Johnson

Address Line 1	Address Line 2
5119 Marla Drive	N/A

City	State	Postal Code
Panama City	FL	32404

SSN (Masked)	Age	Marital	Tenure	Education
XXX-XX-2348	61	Yes	20 months	N/A

Employed	Family Members	House Type	Social Class
Yes	7	Rent	MI

■ COMPLETE INCIDENT DETAILS

Loss Date	Report Date	Hour of Day
May 13, 2020	May 18, 2020	10:00

Incident City	Incident State	Severity
Manchester	CT	Major Loss

PREMIER INSURANCE GROUP

Excellence in Coverage • Trusted Since 1985

TXN00000007

24/7 Helpline: 1-800-555-CLAIM | claims@premierinsurance.com

HEALTH INSURANCE CLAIM

Claim Date: May 13, 2020

Authority Contacted	Any Injury	Police Report
Police	Yes	Yes

■ FINANCIAL & RISK INFORMATION

Premium Amount	Claim Amount	Claim Status
$197.23	$3,000.00	A

Routing Number	Account (Masked)	Risk Segment
72461648	••••••••••••3577	L

Financial Summary:
- Total Claim Amount: $3,000.00
- Monthly Premium: $197.23
- Risk Category: L
- Status: A

■ HEALTH INSURANCE CLAIM DETAILS

Medical Claim Information:
- Treatment Date: May 13, 2020
- Claim Amount: $3,000.00
- Premium Amount: $197.23
- Incident Severity: Major Loss
- Authority Contacted: Police
- Injury Reported: Yes

Required Documents for Health Insurance Claim:
- ■ Medical Bills and Invoices
- ■ Prescription Receipts
- ■ Doctor's Certificate
- ■ Diagnostic Reports (Lab/X-ray/MRI)
- ■ Discharge Summary (if hospitalized)
- ■ Insurance Card Copy
- ■ Claim Form
- ■ KYC Documents

HEALTH INSURANCE CLAIM

Claim Date: May 13, 2020

■ DECLARATION & AUTHORIZATION

DECLARATION:
I hereby declare that all the information provided in this claim form is true, complete, and accurate to the best of my knowledge and belief. I have not withheld any material information that may influence the assessment or settlement of this claim.

AUTHORIZATION:
I authorize Premier Insurance Group and its representatives to investigate this claim, including obtaining information from medical providers, employers, government agencies, and any other relevant parties. I understand that any false statement or misrepresentation may result in denial of the claim and may subject me to legal action.

ACKNOWLEDGMENT:
I acknowledge that the settlement of this claim is subject to the terms, conditions, and exclusions of my insurance policy.

_____ _____

Policyholder Signature **Date**

_____ _____

Witness Signature **Date**