PREMIER INSURANCE GROUP

Excellence in Coverage • Trusted Since 1985

TXN99900002

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

HEALTH INSURANCE CLAIM

Claim Date: January 15, 2025

■ TRANSACTION INFORMATION

Transaction ID	Transaction Date	Agent ID
TXN99900002	January 20, 2025 at 02:00 PM	AGENT00278

Vendor ID	Policy Effective Date
VNDR00075	June 01, 2021

■ POLICYHOLDER COMPLETE INFORMATION

Policy Number	Customer ID	Insurance Type
PLC99900002	A99900002	Health

Customer Name
Robert Clean

Address Line 1	Address Line 2
789 Pine Rd	N/A

City	State	Postal Code
Mesa	AZ	85201

SSN	Age	Marital	Tenure	Education
111-22-3333	50	M	15 months	PhD

Employed	Family Members	House Type	Social Class
Employed	4	Own	Upper

■ COMPLETE INCIDENT DETAILS

Loss Date	Report Date	Hour of Day
January 15, 2025	January 16, 2025	9:00

Incident City	Incident State	Severity
Mesa	AZ	Minor

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Authority Contacted	Any Injury	Police Report
N/A	No	No

■ FINANCIAL & RISK INFORMATION

Premium Amount	Claim Amount	Claim Status
$145.00	$2,500.00	Pending

Routing Number	Account (Masked)	Risk Segment
111222333	•••••5666	Low

Financial Summary:
- Total Claim Amount: $2,500.00
- Monthly Premium: $145.00
- Risk Category: Low
- Status: Pending

■ HEALTH INSURANCE CLAIM DETAILS

Medical Claim Information:
- Provider Name: General Hospital
- Diagnosis Code: E11.9
- Procedure Code: 99214.0
- Treatment Date: January 15, 2025
- Claim Amount: $2,500.00
- Premium Amount: $145.00
- Incident Severity: Minor
- Authority Contacted: nan
- Injury Reported: No

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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

■ 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**