

# PREMIER INSURANCE GROUP

Excellence in Coverage • Trusted Since 1985



TXN55500001

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

## HEALTH INSURANCE CLAIM

Claim Date: December 05, 2025

### TRANSACTION INFORMATION

Transaction ID	Transaction Date	Agent ID
TXN55500001	December 08, 2025 at 09:15 AM	AGENT00413
Vendor ID	Policy Effective Date	
VNDR00556	March 15, 2024	

### POLICYHOLDER COMPLETE INFORMATION

Policy Number		Customer ID	Insurance Type	
PLC55500001		A00003822	Health	
Customer Name				
Christopher Demarest				
Address Line 1		Address Line 2		
7701 West Saint John Road		#2010		
City	State		Postal Code	
Glendale	AZ		85308	
SSN	Age	Marital	Tenure	Education
087-11-1946	54	Yes	89 months	Bachelor
Employed	Family Members		House Type	Social Class
Yes	3		Own	LI

### COMPLETE INCIDENT DETAILS

Loss Date	Report Date	Hour of Day
December 05, 2025	December 06, 2025	14:00
Incident City	Incident State	Severity
Glendale	AZ	Major

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Claim Date: December 05, 2025

### Authority Contacted

Police

### Any Injury

No

### Police Report

Yes

## ■ FINANCIAL & RISK INFORMATION

### Premium Amount

\$165.50

### Claim Amount

\$8,500.00

### Claim Status

Pending

### Routing Number

109134974

### Account (Masked)

.....8465

### Risk Segment

L

### Financial Summary:

- Total Claim Amount: \$8,500.00
- Monthly Premium: \$165.50
- Risk Category: L
- Status: Pending

## ■ HEALTH INSURANCE CLAIM DETAILS

### Medical Claim Information:

- Provider Name: Arizona Medical Center
- Diagnosis Code: J18.9
- Procedure Code: 99285.0
- Treatment Date: December 05, 2025
- Claim Amount: \$8,500.00
- Premium Amount: \$165.50
- Incident Severity: Major
- Authority Contacted: Police
- Injury Reported: No



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## HEALTH INSURANCE CLAIM

Claim Date: December 05, 2025

### 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