PREMIER INSURANCE GROUP

Excellence in Coverage • Trusted Since 1985

TXN00000001

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

HEALTH INSURANCE CLAIM

Claim Date: May 16, 2020

■ TRANSACTION INFORMATION

Transaction ID	Transaction Date	Agent ID
TXN00000001	June 01, 2020 at 12:00 AM	AGENT00413

Vendor ID	Policy Effective Date
VNDR00556	June 23, 2015

■ POLICYHOLDER COMPLETE INFORMATION

Policy Number	Customer ID	Insurance Type
PLC00008468	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 (Masked)	Age	Marital	Tenure	Education
XXX-XX-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
May 16, 2020	May 21, 2020	4:00

Incident City	Incident State	Severity
Savannah	GA	Major Loss

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Authority Contacted	Any Injury	Police Report
Police	No	Yes

■ FINANCIAL & RISK INFORMATION

Premium Amount	Claim Amount	Claim Status
$157.13	$9,000.00	A

Routing Number	Account (Masked)	Risk Segment
109134974	••••••••••••8465	L

Financial Summary:
- Total Claim Amount: $9,000.00
- Monthly Premium: $157.13
- Risk Category: L
- Status: A

■ HEALTH INSURANCE CLAIM DETAILS

Medical Claim Information:
- Treatment Date: May 16, 2020
- Claim Amount: $9,000.00
- Premium Amount: $157.13
- Incident Severity: Major Loss
- Authority Contacted: Police
- Injury Reported: No

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 16, 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**