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Hospital Indemnity Claim Form
For Ector County ISD

Instructions: This form must be completed by the employee for each inpatient hospital admission. It should be used **only when filing a claim for inpatient hospital indemnity benefits.**

To Be Completed By the Employee

1. Name of employee (Last Name, First Name)	Sex ❑ M ❑ F	Date of birth	Member ID number
2. Employed by (name of company) **ECTOR COUNTY ISD**			Group number **004843-0007**

3. Have you terminated employment? ❑ Yes ❑ No
   If yes, date terminated: _____
4. What is the last date you were actively at work? _____
5. Describe the illness or injury requiring treatment: _____
   _____
6. Dates of this hospital stay:
   Admit date _____ Discharge date _____
   YOU MUST PROVIDE A COPY OF THE ITEMIZED BILL FROM THE HOSPITAL FOR THE DATES OF ADMISSION SHOWN ABOVE.

7. Have you submitted a claim form for this hospital admission before? ❑ Yes ❑ No

The above statements are true and complete to the best of my knowledge and belief. I hereby authorize any hospital or doctor who has treated me and any insurance company to furnish any and all medical information to Blue Cross and Blue Shield of Texas, an Independent Licensee of the Blue Cross and Blue Shield Association, or its claim representative. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee's signature _____ Date _____ Year _____

Address _____

City _____ State _____ ZIP _____

Telephone number _____

Submit this claim form to:
Blue Cross and Blue Shield of Texas
P.O. Box 660044, Dallas, TX 75266-0044

Date _____

*Note: All benefits are payable directly to the insured and are not assignable.