MedPlus
Hospital Indemnity Plan

INSURANCE BENEFITS PROVIDED BY
GULF GUARANTY EMPLOYEE BENEFITS SERVICES, INC

A Gulf Guaranty Life Insurance Company
7 River Bend Place
Flowood, MS. 39232
Telephone: 1-800-890-7337 Fax: 601-981-6805
Email: claims@gulfguaranty.com Website: gulfguaranty.com

WELLNESS BENEFIT CLAIM FORM FOR MEDPLUS HOSPITAL INDEMNITY PLAN

Instructions to File a Claim:

- Please complete Insured/Claimant Statement and mail or fax the completed form to the address or fax number indicated above.
- In order to document the contents of this form, the Insured and Claimant (if an adult) must sign and date the completed claim form.
- Please attach a copy of itemized bill indicating patient name, date of service, name of provider, type of service, and diagnosis code.

Insured/Claimant Statement

Insured's Name (Last, First, Middle)	Policy/Certificate #	Social Security No.	Date of Birth	Sex

Address (Street, City, State, Zip)	Phone Number (With Area Code)

Claimant's Name	Date of Birth	Relationship to Insured

Please circle the appropriate wellness screening and provide itemized bill.

Abdominal aortic aneurysm ultrasound	Fasting blood glucose test
Blood test for triglycerides	Flexible sigmoidoscopy
Bone marrow testing	Hemoccult stool analysis
Breast ultrasound	Mammography
CA 15-3 (blood test for breast cancer)	Pap Smear
CA 125 (blood test for ovarian cancer)	PSA (blood test for prostate cancer)
Carotid ultrasound	Serum cholesterol HDL/LDL
CEA (blood test for colon cancer)	Serum protein electrophoresis (blood test for myeloma)
Chest x-ray	Stress Test
Colonoscopy	Thermography
CT Angiography	* **COVID-19 TESTING**
EKG	* Benefit available for testing performed between
Double contrast barium enema	January 1, 2022 and December 31, 2022.

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO GULF GUARANTY LIFE INSURANCE COMPANY, JACKSON MISSISSIPPI, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINIAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE_____ INSURED'S SIGNATURE: _____

DATE_____ CLAIMANT'S SIGNATURE: _____