



**INSURANCE BENEFITS PROVIDED BY
GULF GUARANTY EMPLOYEE BENEFITS SERVICES, INC**

A Gulf Guaranty Life Insurance Company
P.O. Box 14977
Jackson, MS. 39236
Telephone: 1-800-890-7337 Fax: 601-981-6805
Email: claims@gulfguaranty.com Website: gulfguaranty.com

WELLNESS BENEFIT CLAIM FORM FOR DEDUCTIBLE GUARD 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				
Double contrast barium enema				

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN 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 ORIGINAL. 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: _____