MBA Benefit Administrators, Inc.
P.O. Box 57340
Murray, Utah 84157-0340
PHONE (801) 263-3334 (800) 877-3727
FAX (801) 747-5205

Your Claim Cannot Be Considered Properly Until This Information Is Received By MBA

DATE____________________

Insured:___________________________________

Claimant: _________________________________

Date of Accident: __________________________________

IMPORTANT! ***Complete All Items As It Applies To This Claim***

Insured's Employer (Company Name):____

Insured's Name:____

Insured's ID Number:____

The claim we received contains the following information:

Patient Name____

Provider of Service:____

Date of Service:____

This claim appears to have been the result of an accident. In order to maximize your benefits, we will require additional information before your claim can be processed. **Please complete and return this form with the information requested below. Your claim will be finalized when this information is received.**

1. Was this claim the result of an accident? Yes___ No___ (Please check one)
2. Date of Accident ________________________
3. Where did accident happen?____
4. Please provide a brief description of how the accident occurred.
   ____
   ____

Insured Signature: _______________________________ Date: ________________

* Second Request Date. Claim will be placed in inactive file if response is not received within 10 days of this Date.

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