



AFA Veteran Benefits Association
Accident Insurance
Claim for Medical Expense Benefits

Member's Statement

(Must be completed for all claims.)

Full Name: _____ SS# _____

Date of Birth: _____ Telephone #: _____

Present Address: _____
Street Address City State Zip

Marital Status () Single () Married () Widowed () Divorced

Dependent Information

(Complete only if expenses were incurred by an eligible dependent.)

Dependent's Full Name: _____ SS# _____

Date of Birth: _____ Telephone #: _____

Relationship to Membe: _____

Marital Status () Single () Married () Widowed () Divorced

Accident Information

Date of Accident: _____ Time of Accident: _____ () AM () PM

City and State Where Accident Occurred _____

Describe the accident: _____

Physician's Statement

Patient's Name: _____ Date of Injury: _____

Date the Patient First Consulted You for This Condition: _____

Has Patient ever had same or similar symptoms? () Yes () No

Physician's Name: _____

Physician's Address: _____
Street Address City State Zip

Physician's Telephone #: _____

Physician's Signature: _____ Date: _____

Member's Authorization/Signature

I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information requested with regard to this claim and the expenses reported. I certify that the information I furnish in support of this claim is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Member Signature: _____ Date: _____

Dependent Signature: _____ Date: _____
(If claim is for a dependent who is not a minor, dependent must sign.)

IMPORTANT: Attach itemized medical expense bills.
Complete and sign this form and return with itemized bills to:

AFA Veteran Benefits Association
1501 Lee Highway
Arlington, VA 22209-1198

Questions? Call 1-800-291-8480 or E-mail services@afavba.org