ALTERNATIVE CARE BENEFIT CLAIM FORM

Claimants Age 18+ Only

Claim Information

Policyholder Name:______________________________ Policy Number(s):______________________________

Claimant Name:______________________________ Claimant Date of Birth:________/________/________

Instructions

1. Select the type of care prescribed.
2. Complete all fields below.
3. Sign and date the form.
4. Attach a signed and dated prescription from your medical provider.
   Prescription must include:
   a. Type of care being prescribed
   b. Diagnosis for which the care is being prescribed
   c. Start and end date of the care
   d. Recommended frequency for care
5. Include receipts from the care provider. Receipts must include:
   a. The date of service
   b. Charge for service
   c. Provider name and phone number

Type of Care: (Select one)

☐Yoga ☐Meditation ☐ Relaxation Techniques ☐Tai-Chi ☐Acupuncture ☐Therapeutic Massage ☐Nutritional Counseling

Prescribing Doctor Details: (Complete all fields)

Provider Name	Provider Address	Provider Telephone

Treatment Provider Details: (Complete all fields)

Provider Name	Provider Address	Provider Telephone

Acknowledgment

All benefits of this Rider are per Covered Person and are subject to the terms, definitions, provisions, limitations and exclusions of the policy to which it is attached. Any Person who knowingly files a statement of claim containing false, incomplete or misleading information may be subject to civil and criminal penalties. The Provider listed above is authorized to validate the information I have provided.

____ _______/_______/_______

Signature Date