□ Please check here for change of mailing address or phone number.

Texas Police Trust

1600 State Street Houston, Texas 77007
832-200-3410 Fax 832-200-3470

Supplemental Medical Claim Form

INSURED INFORMATION

Insured Name _____ Social Security Number _____ Emp Number _____

Insured Address _____ Daytime Phone Number _____

Insured Date of Birth _____

Primary Insurance (check one) □ **Limited Network Plan** □ **Open Access** □ **Other** □ **Consumer Driven Plan**

Coverage (check one) □ Contract** □ Supplemental

*****A copy of the Patient's City of Houston major medical card must be attached to this claim form.***

DEPENDENT INFORMATION *(PLEASE COMPLETE ALL ITEMS)*

SPOUSE _____ Date of Birth _____

CHILDREN _____ Date of Birth _____

CHILDREN _____ Date of Birth _____

CHILDREN _____ Date of Birth _____

CHILDREN _____ Date of Birth _____

CHILDREN _____ Date of Birth _____

Comments _____

I authorize release of any medical information necessary to process this claim.

Patient's or Authorized Signature _____ Date _____