



**WEA Administrators**  
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**SECTIONS A, B, C, D TO BE COMPLETED BY INSURED** - Please be sure to provide all requested information and include original itemized bills (invoices) from the healthcare provider. Photocopies of documents are not acceptable.

## A. INSURED (SUBSCRIBER) INFORMATION

1. Insured's Name (Last, First, MI)	<input type="text"/>	2. Alias Name(s)	<input type="text"/>
3. Mailing Address	<input type="text"/>		
Country:	<input type="text"/>	Zip / Postal Code:	<input type="text"/>
4. E-mail Address	<input type="text"/>		
5. Home Phone Number	<input type="text"/>	6. Policy Number	<input type="text"/>
7. Work Phone Number	<input type="text"/>	8. Fax Number	<input type="text"/>

## B. PATIENT INFORMATION

9. Patient's Name (Last, First, MI)	<input type="text"/>	10. Alias Name(s)	<input type="text"/>
11. Patient's Date of Birth (MM/DD/YY)	<input type="text"/>	12. Patient's Relationship to Insured	<input type="text"/>
13. Describe Illness or Injury <i>(If maternity, please complete and include maternity form)</i>	<input type="text"/>		
	14. Date of Illness (first symptoms) or Accident (MM/DD/YY)	<input type="text"/>	
15. Do you or any member of your immediate family have any other insurance that may cover all or part of this claim? Yes <input type="checkbox"/> No <input type="checkbox"/>			
16. If yes (to #16), give insurance company name, address & policy # and Effective Date. <input type="text"/>			

## C. ASSIGNMENT OF BENEFITS

17. Assignment: Please pay provider directly to the address indicated on the attached original provider invoice.		Yes <input type="checkbox"/>	No <input type="checkbox"/>
18. Insured's Signature	<input type="text"/>	19. Date Signed	<input type="text"/>

## D. AUTHORIZATION TO RELEASE INFORMATION

I certify that the above statements are true and correct to the best of my knowledge and hereby authorize any physician, hospital, employer, union, insurance company, HMO, or prepayment organization to supply each other any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

20. Insured's Signature	<input type="text"/>	21. Date Signed	<input type="text"/>
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## E. FRAUD WARNING

Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

