AVEGA
LEADING EDGE HEALTHCARE SOLUTIONS

INTERNMENT ASSISTANCE CLAIM FORM

BASIC REQUIREMENTS:

1. Xeroxed Death Certificate with original authentication
2. Xeroxed Birth Certificate with original authentication
   * Deceased * Beneficiary
3. Xeroxed Marriage Contract with oiginal authentication (if married)
4. Certificate of Employment
5. Latest DTR
6. Certificate of Claimant (3 copies)
7. Certificate of Attending Physician
8. Police Report and Autopsy (if accidental death)

ALL QUESTIONS TO BE ANSWERED IN FULL

GENERAL DATA OF DECEASED MEMBER

1. a. Full name (Please print) _____
   b. If deceased was a married woman, state maiden name _____
2. a. Date of birth _____ b. Place of birth _____
   c. Source from which date of birth was obtained _____
   (Family record or other record or certificate of birth should be referred to)
3. Residence at death _____
4. a. Place of death _____ b. Date of death _____
   c. Cause of death _____ d. Age at death _____
5. a. Occupation at date of death _____
   b. Date deceased last attended his usual work _____

HEALTH HISTORY OF DECEASED

1. Date deceased first complained or showed symptoms of last illness _____
2. Date deceased first consulted a physician of last illness _____
3. Name and addresses of all physicians who attended deceased during his last illness and/or hospitals or other institutions in which the deceased was confined or received treatment.

Name of Physician/Hosp./Institution	Address	Date of Attendance/Confinement From	To	Disease or Condition

DATA OF BENEFICIARY-CLAIMANT

1. a. In what capacity, or by what title, do you claim this assistance? _____
   b. What is your relation to the deceased? _____
2. Please state your date of birth _____ (if a married minor or surviving spouse, please submit marriage certificate)

The undersigned hereby makes claim to the internment assistance of the deceased in the AVEGA Managed Care, Inc. and agrees that the written statements and for by the instructions hereon, shall constitute and they are hereby made a part of these Proofs of Death.affidavits of all the physicians who attended or treated the deceased and all other papers called

Dated at _____ this _____ day of _____ 20 _____

_____ Signature of Witness

_____ Signature of Beneficiary-Claimant

_____ Name of Witness (Please print)

_____ Address of Beneficiary-Claimant

CERTIFICATE OF AUTHORIZATION

This is to authorize AVEGA Managed Care, Inc. and/or its duly authorized representative to secure whatever information or records are available from government and Private on the internment assistance to the family of the deceased member.hospitals and offices. This authorization is being made in connection with a claim

It is understood that any action you may take in connection with this authorization releases you or any and all members of your staff form any responsibility or obligation in connection with the release of such records of information.

_____ Signature of Witness

_____ Signature of Beneficiary-Claimant

_____ Name of Witness (Please print)

_____ Print name and signature

Residence Certificate No. _____
Issued at _____ on _____