MUTUAL ASSURANCE ADMINISTRATORS, INC.

ANNUAL DATA FORM

MAA Internal Use Only
Group #: ____________
Entered: ____________

MAA members frequently ask what they can do to expedite the processing of their claims. By completing this form you will enable MAA to maintain a current profile of you and any family members covered by your Plan, eliminating the need to request this information at the time your claim is processed. **Please complete each question, read the AUTHORIZATION on the reverse side of this form, then sign and date where indicated. AN INCOMPLETE FORM WILL REQUIRE US TO REQUEST THIS INFORMATION AT THE TIME A CLAIM IS RECEIVED CAUSING A DELAY IN PROCESSING YOUR CLAIM**. Thank you for your cooperation.

1. Employee's Full Name:____________________ Employer's Name:____________________ SSN: ______-______-______

Home Address:____________________ May we contact you by e-mail? If yes, what address:____________________

City:__________ State:_________ Zip:__________ Home Phone #: (____)__________ Work Phone #: (____)__________

2. NAME OF SPOUSE **(First, Middle Initial, Last)**	**3.** DATE OF BIRTH MM/DD/YY	**4.** SSN	**5.** SEX	**6.** Does your spouse reside with you full-time? **(If no, please provide spouse's address)**
	____/____/____	______-____-______	❑ Male ❑ Female	❑ Yes Address:____________________ ❑ No ____________________

7. NAME OF DEPENDENT(S) **(First, Middle Initial, Last)**	**8.** RELATIONSHIP TO YOU **(Please specify, e.g. son, stepson, nephew, grandson, etc.)**	**9.** DATE OF BIRTH MM/DD/YY	**10.** SSN	**11.** SEX	**12.** Does he/she reside with you full-time? **(If no, please provide dependent's permanent address and full name of guardian)**
		____/____/____	______-____-______	❑ Male ❑ Female	❑ Yes Name: ____________________ ❑ No Address: ____________________ ____________________
		____/____/____	______-____-______	❑ Male ❑ Female	❑ Yes Name: ____________________ ❑ No Address: ____________________ ____________________
		____/____/____	______-____-______	❑ Male ❑ Female	❑ Yes Name: ____________________ ❑ No Address: ____________________ ____________________
		____/____/____	______-____-______	❑ Male ❑ Female	❑ Yes Name: ____________________ ❑ No Address: ____________________ ____________________

IF YOU NEED MORE SPACE FOR ADDITIONAL DEPENDENTS, PLEASE ATTACH A SEPARATE SHEET PROVIDING ALL RELATED INFORMATION.

IF ANY OF YOUR DEPENDENTS ARE AGE 19 OR OVER, PLEASE PROVIDE A LETTER OR COPY OF ENROLLMENT FORM FROM THE COLLEGE SHOWING THE NUMBER OF CREDIT HOURS FOR THE CURRENT SEMESTER. THIS INFORMATION IS NEEDED EACH SEMESTER.

13. Do you and/or any of the individuals named above have other group health or Medicare coverage? ❑ Yes ❑ No

If yes, please list name(s) of covered individual(s): ______________________________ **and provide the following:**

❑ Medical Name of Insured: ____________________ SSN: ______-______-______ Group #: ____________________
❑ Dental Name of Other Ins. Co: ____________________ Policy #: ____________________
❑ Vision Address: ____________________ Phone #: (____)__________

Form No. ADF-01 (REC 11/02)

AUTHORIZATION

14. I authorize any physician, dentist, medical practitioner, hospital, clinic, pharmacy or any other provider of health care, any insurance company, government agency or consumer reporting agency to disclose to Mutual Assurance Administrators, Inc., or my employer all information and records relating to a diagnosis, medical history, physical or mental condition and evaluation, or any other information relating to me or my dependents. I understand that any information obtained will not be released to any person or organization except its reinsurers, other persons or organizations performing business or legal services in connection with my coverage, or as may be required by law, or as I may further authorize. A photocopy of this authorization remains valid for the term of coverage. I have a right to receive a copy of this authorization upon request.

The information authorized for release may include information, which may be considered a communicable, or venereal disease, which may include, but is not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC).

I release anyone providing this information from all legal responsibility or liability that may arise from this Authorization.

______________________________ ______________________________
Employee's Signature Date

______________________________ ______________________________
Spouse's Signature Date

REV 11/02

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PLACE
STAMP
HERE

Mutual Assurance Administrators, Inc.
P. O. Box 42096
Oklahoma City, OK 73123-3096

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