RBMS LLC
Risk & Benefit Management Services

P.O. Box 241569 Anchorage, Alaska 99524-1569
Phone 907-561-3740 1-800-770-3740 Fax 907-561-8813

Date: ____

Name: ____

Address: ____

City, ST, Zip ____

Employer: ___________________________ Group# ___________

Patient Name: _______________________________________

Employee: ____

Employee SS#: _______________________________________

We have received a claim______________________ from dated ____________________
We need the following information before we can process this claim:

1. Is ______________________________________ a full-time student at an institution?
   of higher learning? Yes________ No________

2. If yes, please answer questions A and B.
   A. Name of School and Location ____.

B. Individual has been or will be enrolled in
_____Spring Semester 2005 _____Yes _____No
_____Summer Semester 2005 _____Yes _____No
_____Fall Semester 2005 _____Yes _____No

C. Number of credits per Semester __________

We have enclosed a self-addressed envelope for your convenience for returning this completed form. Your claim will be pending until we receive your response.

EMPLOYEE SIGNATURE____________________________DATE________________