P O Box 809043 Dallas, TX 75380
Fax: 972-726-6028
Office: 800-527-0996
nfcbenefits.com
claims@nfclife.com

Express Filing of Wellness Benefit

For Express filing, you must send the completed form along with the following information from your doctor:

- **T**he type of wellness screening that was performed, the date of service, and a copy of the bill.
- If you are treated at a non-cost incurred facility, please furnish verification from the facility of the date and type of test performed.

Please complete all sections

This claim is for: ___Spouse ___Dependent ___Self

1.Personal Information

Policyholder Name (First, Middle, Last):

Policy Number: Social Security Number:

Birth Date (MM/DD/YYYY):

Address:

City: State: Zip:

2. Patient's Name – If Not Self

Name (First,Middle,Last):

Patient's Social Security Number:

Birth Date (MM/DD/YYYY):

3. Policyholder Email Address

Email:

4. Date Test Performed

(Date MM/DD/YYYY):

5. Doctor's Information

Name:

Address:

City: State: Zip:

Phone: Fax:

Please Note: Your Policy does not provide benefits for routine physical examinations. Please review your policy for the list of covered tests.

Certification

Policyholder's Signature **Date**

Patient's Signature **Date**

I have checked the answers on this claim form, and they are correct. I certify under penalty of perjury that my correct Social Security Number is shown on this form.