CPM, Inc.
GAP CLAIM FORM

1220 SW Executive Drive
Topeka, KS 66615
ATTN: Claims

Phone: (785) 273-8398
Toll Free: (800) 999-1781
Fax: (785) 273-6850

Employee Name: _____ SS #: _____

Address: _____

(All payments are sent directly to employee)

Claimant Name (If Other Than Employee): _____ DOB: _____

Employer Name: _____

Date(s) of Service _____

Provider(s) Name(s) _____

(Be sure to include copy of your Explanation of Benefits –EOB – with this claim form)

I hereby agree to reimburse the Plan to the extent of any overpayment which is in excess of the amounts payable under the group plan administered by Corporate Plan Management. I hereby certify that the statements hereon are complete and accurate to the best of my knowledge. I also hereby authorize any insurance company, hospital or physical to release all information which may have a bearing on benefits payable under this Plan.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE PLAN, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER FEDERAL LAW.

Signature of Insured: _____ Date: _____

Please be sure to include copy of Explanation of Benefits with this claim form
All payments will be sent directly to the Employee