Accident and Supplemental Hospital and Medical Indemnity Claim Instructions

- 1. Please complete sections 1 through 6.
- 2. Read and sign the Authorization, section 8. The authorization will be used in obtaining information needed to process your claim. Failure to complete the Authorization will result in a delay in processing.
- 3. If your loss is the result of an Accident, please provide a complete description of your accident. If the accident was a motor vehicle accident attach a copy of the police or accident report. If you were injured in an on-job or occupational injury, attach a copy of the first report of injury filed with your employer.
- 4. If you were first treated at an emergency room, please attach a copy of the discharge papers from the hospital in order for us to verify the first date of treatment.
- 5. Please attach a copy of all bills and supporting documents related to the treatment of your loss. The medical bills and supporting documents should include the diagnosis, the specific procedure or treatment the covered insured received, the date of service, and the amount charged for physician services, emergency room treatment and supplies. If you are filing for hospital confinement benefits, attach a copy of the itemized hospital bill showing the number of days of hospitalization or an admission and discharge summary.
- 6. If you are filing during the first year of your coverage effective date and subject to a pre-existing investigation, complete the enclosed pre-existing statement form in full and return to our office with your claim form.

PART A POLICYHOLDER/CLAIMANT'S STATEMENT								
1	EMPLOYER'S NAME				POLICYHOLDER'S E-MAIL ADDRESS			
	POLICYHOLDER'S NAME POLICY/CERTIFICATE N			POLICY/CERTIFICATE NO.	DATE OF BIRTH SEX			
2								
	POLICYHOLDER'S ADD	DECC	STREET		CITY	STA	TE ZIP CODE	
3	POLICY HOLDER'S ADD	KESS	SIREEI		CITY	SIA	TE ZIP CODE	
	CLAIMANT'S NAME (PERSON WHO IS SICK OR INJURED) DATE OF BIRTH				RELATIONSHIP TO POLICYHOLDER'S TELEPHONE NO. (INCLUDE AREA CODE)			
4	CENTIFICATION OF TANKE (I E	NOON WITE	TO GIOR OR INDURED)	DATE OF BIRTH	POLICYHOLDER	T OLIO MIOLDERO TELE	THORE NO. (INCLUDE AREA GODE)	
	DESCRIBE WHEN AND HOW YOUR ACCIDENT OCCURRED OR THE ONSET AND NATURE OF			YOUR ILLNESS.				
5								
	IS YOUR ACCIDENT OR SICKNESS RELATED TO YOUR OCCUPATION				HAS A WORKER'S COMPENSATION CLAIM BEEN FILED?			
6	IS TOUR ACCIDENT ON GIONNECO NELLATED TO TOUR OCCUPATION				□ NO STATUS			
	□ NO □ YES DATE SYMPTOMS ■ DOCTOR TREATED OR REFERRED BY WITHIN THE LAST YEAR:						NDING DENIED	
	DATE SYMPTOMS FIRST APPEARED							
		<u>DATE</u>	<u>NAME</u>	<u>ADDRESS</u>	CIT	<u>Y STATE</u>	ZIP CODE TELEPHONE NO.	
7								
	IF HOSPITALIZED WITHIN THE LAS							
		DATE	<u>NAME</u>	<u>ADDRESS</u>	<u>CIT</u>	<u>Y STATE</u>	ZIP CODE TELEPHONE NO.	
AUTHORIZATION Several states require that the following statement appear on the claim forms:								
	Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.							
	I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included with this form.							
8	Policyholder's Signature:				Date:			
	Claimant's Signature:					Deter		
						Date:		