Claims Made Easy

HELPFUL TIPS:

First page (Claimant completes)
Please include your complete name and current mailing address on the claim form as any payment and/or correspondence will be sent to the address indicated on the claim form. Indicate your policy numbers/certificate numbers on the claim form; this will help us respond quicker.

Accident: For loss due to an accidental bodily injury, please complete the Accident section of the form including a detailed description of how the accident occurred.

Sickness: If filing for loss due to sickness, fill in the section of the form relating to symptoms and diagnosis. You may be requested to provide additional details regarding medical treatment you received within the 5 years prior to your policy effective date.

Critical Illness: If filing a critical illness claim, please fill in the date of diagnosis and provide a copy of the pathology report or test results confirming the diagnosis and the level of severity.

Hospitalization: If hospitalized, provide us with the name and address of the hospital including the admission and discharge dates. Please also send a copy of the itemized hospital bill including the number of days you were an inpatient.

Disability: If you were disabled and have disability coverage, give the exact dates of the total and/or partial disability. If you are still disabled at the time you submit your claim form, another claim form will be sent to you for continuing disability.

Wellness: If filing for wellness/preventative/health screening benefits, please review your policy carefully to ensure the test or procedure is covered under your policy. Do not use the attached claim form if filing for wellness or health screening benefits. Rather use the Health and Wellness claim form which can be found at www.combinedinsurance.com/forms.

Complete all sections of the Claimant Statement.

Your primary physician must complete **Section D – Attending Physician's Statement** in its entirety. Failure to make sure that your physician fills in all necessary information on the claim form may cause delays in the processing of your claim.

Review the Fraud Notification for your state

Sign and date the Authorization to Obtain and Disclose Health Information.

Combined Insurance Company of America

Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700 • Telephone 1-800-225-4500 • Fax 312-351-6930

IMPORTANT INSTRUCTIONS FOR FILING CLAIM

1. USE THIS CLAIM FORM FOR ALL CLAIMS EXCEPT FOR WELLNESS/PREVENTATIVE/HEALTH SCREENING BENEFITS.
2. IF DISABILITY IS CLAIMED, PLEASE HAVE YOUR EMPLOYER OR SCHOOL COMPLETE SECTION C, THE EMPLOYER'S STATEMENT.
3. IF MEDICAL OR HOSPITAL BENEFITS ARE CLAIMED, ITEMIZED BILLS MUST BE ATTACHED.

SECTION A — **CLAIMANT STATEMENT**

PLEASE PRINT

FIRST NAME | LAST NAME | M.I.

E-MAIL ADDRESS (Your e-mail address will be updated with this information if different from the e-mail on file)

PLEASE LIST OTHER NAMES THAT YOU MAY USE SUCH AS MAIDEN NAME, NICKNAME, ETC. | PRIMARY PHONE | SECONDARY PHONE

MAILING ADDRESS

CITY | STATE | ZIP

SOCIAL SECURITY # (LAST 4 DIGITS) | BIRTH DATE (MM/DD/YYYY) / / | HEIGHT (FT/IN) | WEIGHT (LBS) | MALE | FEMALE

POLICY/CERTIFICATE NUMBER(S)

EMPLOYER'S NAME

EMPLOYER'S ADDRESS

CITY | STATE | ZIP

EMPLOYER'S CONTACT NAME | EMPLOYER'S CONTACT PHONE NUMBER | EMPLOYER'S CONTACT FAX NUMBER

YOUR OCCUPATION | MONTHLY EARNINGS $,

BRIEFLY DESCRIBE YOUR OCCUPATIONAL DUTIES

HAVE YOU FILED A CLAIM UNDER THE FOLLOWING:

WORKERS' COMPENSATION ACT? YES NO

SOCIAL SECURITY ACT? YES NO

STATE DISABILITY BENEFITS? YES NO

IF YES TO ANY OF THE PRECEDING, PLEASE SUBMIT A COPY OF THE AWARD OR DENIAL LETTER IF RECEIVED.

IF YOU HAVE OTHER ACCIDENT-SICKNESS DISABILITY INSURANCE, GIVE COMPANY NAME, ADDRESS, AND BENEFIT AMOUNT. (IF NONE, STATE "NONE")

COMPANY NAME

ADDRESS

CITY | STATE | ZIP

BENEFIT AMOUNT

WEEKLY $, | BI-WEEKLY $, | MONTHLY $,

Statements made by you on this claim form must be true and complete. Please review the Fraud Warning for your state on the attached Fraud Notification pages. You must sign and date this claim form on the signature line provided on the Fraud Notifications page. ***If you do not sign this Fraud Notifications page, we cannot accept your claim submission.***

SECTION D — ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S FIRST NAME | LAST NAME | M.I. | AGE

ADDRESS

CITY | STATE | ZIP

NATURE AND ORIGIN OF: ☐ SICKNESS ☐ INJURY

DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY)

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN? (MM/DD/YYYY) / /

WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? (MM/DD/YYYY) / /

IF SICKNESS, WHEN WAS CONDITION FIRST DIAGNOSED? (MM/DD/YYYY) / /

INDICATE THE DATE AND TYPE OF DIAGNOSTIC TEST USED TO DIAGNOSE CURRENT CONDITION. IF MORE TESTS WERE PERFORMED, PLEASE INCLUDE SUPPORTING DOCUMENTATION. (MM/DD/YYYY) / /

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☐

(IF "YES", STATE WHEN AND DESCRIBE.) (MM/DD/YYYY) / /

HOW DID CONDITION ORIGINATE?

DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION.

NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE(S), IF ANY. (DESCRIBE FULLY)

DATE (MM/DD/YYYY) / /

PROCEDURE

NAME OF FACILITY

OPEN OR CLOSED REDUCTION

OPEN ☐ CLOSED ☐

GIVE DATES OF TREATMENT AND NATURE OF TREATMENT OTHER THAN SURGICAL.

OFFICE — DATE (MM/DD/YYYY) / / ; / / ; / /

NATURE OF TREATMENT(S)

NAME OF FACILITY

EMERGENCY ROOM (ER) — DATE (MM/DD/YYYY) / /

NATURE OF TREATMENT

NAME OF FACILITY

URGENT CARE FACILITY — DATE (MM/DD/YYYY) / /

NATURE OF TREATMENT

NAME OF FACILITY

IS THE PATIENT STILL UNDER YOUR CARE? YES ☐ NO ☐

HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?

FROM (MM/DD/YYYY) / / THROUGH (MM/DD/YYYY) / /

HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? (ONLY ABLE TO WORK PART TIME OR PERFORM PARTIAL JOB DUTIES)?

FROM (MM/DD/YYYY) / / THROUGH (MM/DD/YYYY) / /

PLEASE STATE RESTRICTIONS PLACED ON PATIENT FOR ANY DISABILITY THAT HAS BEEN INDICATED.

IF PATIENT DISABLED ON DATE YOU COMPLETE THIS FORM, IS THERE A RETURN TO WORK DATE?

YES ☐ NO ☐ (IF "YES", GIVE RETURN TO WORK DATE.)

RETURN TO WORK DATE (MM/DD/YYYY) / /

IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT.

HOSPITAL NAME

ADMISSION DATE (MM/DD/YYYY) / /

DISCHARGE DATE (MM/DD/YYYY) / /

ADDRESS

CITY | STATE | ZIP

PHYSICIAN'S NAME | DEGREE | SIGNATURE

PHONE NUMBER | FAX NUMBER | DATE (MM/DD/YYYY) / / | STAMP

ADDRESS

CITY | STATE | ZIP

MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE

INDIVIDUAL PRACTITIONER'S S.S. NO. | ALL OTHERS - EMPLOYER I.D. NO.