

CLAIMANT'S STATEMENT FOR HOSPITAL INDEMNITY CLAIM

Please complete the Claimant's Statement, answering ALL questions on the form. Please complete the Authorization to Release Information and Medical Provider & Employer List. Please submit the completed forms to the above address along with the following information:

- (1) A full copy of the Accident or Police Report and a copy of the Emergency Room Records (including alcohol and drug test results if testing was performed) is required for all Motor Vehicle Accidents.
- (2) Attending Physician's Statement completed by the physician.
- (3) A fully itemized statement of expenses from the Physician, Hospital or Emergency Room. Please include a copy of the Physician's records or a copy of the Admit and Discharge Summary (not the documents given to you when discharged).
- (4) A fully itemized statement of expenses if you received services from any of the following providers:
 - a) Physician's Office, Physician's Clinic Urgent Care Facility.

POLICYHOLDER'S NAME _____ POLICY NUMBER(S) _____
ADDRESS _____

PHONE _____ - _____ - _____ SSN _____ - _____ - _____ DATE OF BIRTH _____ - _____ - _____

CHECK HERE IF NEW ADDRESS MALE FEMALE

Employer's Name: _____ Employer's Phone: _____ - _____ - _____

Employer's Address: _____

Supervisor's Name: _____

THIS CLAIM IS ON: INSURED YOUR SPOUSE YOUR CHILD MALE FEMALE

If the claim is on your spouse or child, please complete the following:

Patient's Name _____ SSN _____ - _____ - _____

Date of Birth _____ - _____ - _____ Relationship to Policyholder _____

What condition are you claiming? _____

What date did you first consult the Physician for this condition? _____ - _____ - _____

Primary Physician's Name: _____

Address: _____ Phone _____ - _____ - _____

1st Physician's Name _____

Address _____ Phone _____ - _____ - _____

2nd Physician's Name _____

Address _____ Phone _____ - _____ - _____

If you were hospitalized: Date Admitted _____ - _____ - _____ Date Discharged _____ - _____ - _____

Name of Hospital _____

Address of Hospital _____

Date Injured _____ - _____ - _____ Time of Accident _____ Where did accident happen? _____

Did the accident happen while working on-the-job? Yes No

Tell us exactly how the accident happened. _____

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent Insurance act, which is a crime.

I certify the above information is true to the best of my knowledge.

Signature _____ Date _____ - _____ - _____