Claims Made Easy

For faster claim payment* please submit your claim online at www.CombinedInsurance.com/Claims

FILING A CLAIM BY MAIL

1. Download the claim form
2. Print all six pages of the claim form
3. Complete the first page of the claim form including Section B or C and Sections D and E.
4. Sign and date the first page. There are two areas for your signature marked with an “X” at the bottom of the first page
5. Have your doctor complete the Attending Physician’s Statement on the second page.
6. If you are claiming disability, have your employer complete the Employer’s Statement found at the top of the second page.
7. Sign and date the Fraud Notification on page 5 of the claim form.
8. Send your signed completed claim form with the Physicians Statement, Employer Statement if applicable, and any medical bills or reports that you may have related to your accident or illness to:

   Combined Insurance Claim Department
   PO Box 6700
   Scranton, PA 18505-0700

* on average claims submitted online receive claim payments faster

Combined Insurance Company of America | Chicago, IL
In New York: Combined Life Insurance Company of New York | Latham, NY

COMBINED INSURANCE®
A Chubb Company

C-CLMS-FRM-1-0518

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 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.

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 total and/or partial disability. If you are still disabled at the time you submit the form, another form will be sent to you for continuing disability.

Additional: Please be sure to sign and date the **Authorization to Release Information** located near the bottom of the form. This will prevent unnecessary delays in the event additional information is needed.

Second page (Employer and Doctor complete)

If you are employed outside the home, your employer must verify your disability by completing **Section F – Employer's Statement**. If the insured is a student, the school principal should complete this section.

The primary physician must complete **Section G – Attending Physician's Statement** in its entirety including the diagnosis, a description of how the condition originated and dates of treatment. If your claim involves disability and / or hospital confinement, these dates must also be included by your physician. **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.**

For your records, we suggest that you keep a copy of the completed claim form and any bills you submit. Note the date mailed. Mail both pages of the completed form and any enclosures to:

Combined Insurance Claims Department
P O Box 6700, Scranton, PA 18505-0700

Remember, you get paid 10 days faster* when you submit a claim online at www.CombinedInsurance.com/Claims

* On average

Combined Insurance Company of America | Chicago, IL
In New York: Combined Life Insurance Company of New York | Latham, NY

COMBINED INSURANCE®
A Chubb Company

Combined Insurance Worksite Solutions
A unit of Combined Life Insurance Company of New York
CLAIM DEPARTMENT • PO BOX 6700
SCRANTON, PA 18505-0700
1-888-441-7936
Fax Number: 1-312-351-6930

IMPORTANT INSTRUCTIONS FOR FILING CLAIM FOR DISABILITY/LOSS OF TIME
The form must be completed in detail including the employer's statement in Section C.

Section A.
PLEASE PRINT—DO NOT WRITE

Claimant's Full Name (Mr. / Mrs. / Miss)	Relationship to Policy/certificateholder	Full time Student
	☐ self ☐ spouse ☐ child	☐ Yes ☐ No
Please list other names that you may use such as maiden name, nickname, etc.	Social Security # (Last 4 digits)	Area Code Home Phone ( )
Address (Mailing Address and No.) City State Zip	Policy/Certificate	E-Mail Address
Mo. Day Year / Birth Date / Height / Weight		Occupation

Briefly describe your occupational duties:

Employer's Name and Complete Address:

Are you filing claim under Workers' Compensation Act or Social Security Act? If yes, please submit a copy of the award or denial, when received. ☐ Yes ☐ No	Is claimant eligible for Medicaid or a similar state program? ☐ Yes ☐ No

If you have other accident-sickness disability insurance give company name, address and monthly benefit amount. (if none, so state)

Section B.
Please complete below and attach itemized copies of any related bills, including doctor, emergency room, hospital and motor vehicle incident/accident report. Bills should include diagnosis information from your medical provider.

Date of accident Mo. / Day / Year	Time of accident AM PM	Nature of injuries	Date of first symptoms	Nature of sickness

Please provide an exact description of where you were when accident occurred including a detailed description of what happened to you.

Hospital's name and address and telephone #

Dates of confinement

Attending physicians' names and addresses

Dates of treatment

A) **TOTAL DISABILITY:** Between what dates were you unable to perform any duties? A) From Mo. / Day / Year through Mo. / Day / Year

B) **DATE RETURNED TO WORK:** B) Mo. / Day / Year

C) **PARTIAL DISABILITY:** Between what dates were you able to perform only partial duties? C) From: Mo. / Day / Year through Mo. / Day / Year

WOULD IT BE ALRIGHT IF, DURING THE NEXT YEAR, WE MENTION YOUR CLAIM BENEFITS WHEN TALKING TO PROSPECTIVE POLICYHOLDERS ABOUT OUR CLAIM SERVICE? Yes ☐ No ☐ IF YOU WISH TO DISCONTINUE THIS AUTHORIZATION AT ANY TIME, PLEASE CALL US AT 1-888-441-7936. Thank you.

DATED: Mo. / Day / Year

SIGNED: X _____
CLAIMANT'S SIGNATURE

If your policy/certificate is paid with pre-tax dollars, benefits paid may need to be reported to the IRS. Contact your employer regarding reporting requirements.

The statements made by me on this claim form are true and complete.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Claimant X _____ Please Print Name _____

I signed on behalf of the claimant, as _____ (relationship). If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Section C.

EMPLOYER'S STATEMENT (necessary for All Disability / Loss of Time claims)

Employee's Name	Date Last Worked	Salary	
		$	☐ Weekly ☐ Monthly

Workers' Compensation claim filed for this disability? ☐ Yes ☐ No — If yes, name, address and telephone number of compensation carrier:

TOTAL DISABILITY:
Between what dates was the employee unable to perform their duties? From Mo. / Day / Year through Mo. / Day / Year

PARTIAL DISABILITY:
Between what dates did employee give up only part of duties? From Mo. / Day / Year through Mo. / Day / Year

During partial disability, did/will employee receive 75% or more of his pre-disability income? ☐ Yes ☐ No
If no, what percentage?_____

Date	Title	Signature	Area Code	Phone Number

Section D.

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name	Address	City, State, Zip Code	Birthdate

1. Is patient still under your care for this condition? ☐ Yes ☐ No
   If discharged, give date, and degree of recovery. Date Mo. / Day / Year Recovered? ☐ Yes ☐ No
2. How long was or will patient be continuously totally disabled (unable to perform any duties)? From Mo. / Day / Year through Mo. / Day / Year
2A. If presently totally disabled, when do you think patient will be able to return to work? Approximate date: Mo. / Day / Year ☐ Indefinite ☐ Never
3. How long was or will patient be partially disabled (able to perform only part of duties)? From Mo. / Day / Year through Mo. / Day / Year

DATE OF CURRENT: MM DD YY ◄ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	PHONE NUMBER OF REFERRING PHYSICIAN	ADDITIONAL HOSPITALIZATION DATES FROM MM DD YY TO MM DD YY
IS PATIENT'S CONDITION RELATED TO: EMPLOYMENT ☐ YES ☐ NO AUTO ACCIDENT ☐ YES ☐ NO OTHER ACCIDENT ☐ YES ☐ NO		IF OTHER ACCIDENT, PROVIDE BRIEF DESCRIPTION BELOW.
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM BY LINE) 1. ____.__ 2. ____.__ 3. ____.__ 4. ____.__		

	DATE(S) OF SERVICE From MM DD YY	To MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	
1									
2									
3									
4									
5									
6									

FEDERAL TAX I.D. NUMBER:	SIGNING PHYSICIAN CERTIFIES ABOVE DISABILITY DATES, IF ANY.
PHYSICIAN'S NAME	SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR CREDENTIALS
COMPLETE ADDRESS	
TELEPHONE / DATE MM DD YY	

COMBINED INSURANCE®

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Claim or Policy Number: _____

Name: _____ Doctor's Name: _____

Address: _____ Hospital's Name: _____

Birthdate: _____ /_____ /_____ Adm. ____ /____ /____ Disch. ____ /____ /____

This will authorize WORKSITE SOLUTIONS, a unit of COMBINED LIFE INSURANCE COMPANY OF NEW YORK, PO BOX 6700, Scranton, PA, 18505-0700 to obtain necessary medical information for the purposes of evaluating my insurance claim. The information to be obtained shall include information from any Prescription Drug Database, all health care providers, employer, consumer reporting agency, any other insurance company, or the "MIB" (Medical Information Bureau), which is relevant to my loss or condition being evaluated.

The information to be disclosed may include but is not limited to:

History of Present Illness
Operative Reports
Daily Doctor's Notes
X-Ray Reports
Consultant's Report
Pathology Reports
Past Medical History
Blood/Toxicology
Discharge Summary
Laboratory Results
Previous Admissions

The information is needed for the following purpose(s):
Evaluation and processing of my insurance claim

I understand that the information released by this authorization may also include information concerning treatment of physical and mental illness, HIV, alcohol/drug abuse and past medical history.

I understand upon fulfillment of the above stated purposes, this consent will automatically expire (6) months following date of signature without any express revocation. I understand and I have the right to revoke this authorization at any time, and in order to do so, I must present a written revocation to Combined Insurance Company of America. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy/certificate or evaluate my insurance application for coverage.

Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by the federal confidentiality rules. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the individual's authorization.

X _____ Date: _____
(Signature of Parent or Guardian) (Must be filled in)

X _____ _____
(Signature of Witness) (Relationship to Patient if Signed by Guardian)

A photocopy of this authorization may be treated in the same manner as an original.