

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 48585-0700

* on average claims submitted online receive claim payments faster

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 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 <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child			Full time Student <input type="checkbox"/> Yes <input type="checkbox"/> 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	Height	Weight				Occupation	

Birth Date _____
 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. <input type="checkbox"/> Yes <input type="checkbox"/> No				Is claimant eligible for Medicaid or a similar state program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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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	
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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	
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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.**

Mo. Day Year
 DATED: / /

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	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	
		\$		
Workers' Compensation claim filed for this disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name, address and telephone number of compensation carrier:		
TOTAL DISABILITY:		Mo.	Day	Year
Between what dates was the employee unable to perform their duties?	From	/	/	through
PARTIAL DISABILITY:		Mo.	Day	Year
Between what dates did employee give up only part of duties?	From	/	/	through
During partial disability, did/will employee receive 75% or more of his pre-disability income?		<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If discharged, give date, and degree of recovery.				
	Mo.	Day	Year	Recovered? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date	/	/	
2. How long was or will patient be continuously totally disabled (unable to perform any duties)?				
	Mo.	Day	Year	Mo.
	From	/	/	through
2A. If presently totally disabled, when do you think patient will be able to return to work?				
	Approximate date:	Mo.	Day	Year
		/	/	
				Indefinite <input type="checkbox"/> Never <input type="checkbox"/>
3. How long was or will patient be partially disabled (able to perform only part of duties)?				
	Mo.	Day	Year	Mo.
	From	/	/	through
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 <input type="checkbox"/> YES <input type="checkbox"/> NO AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> 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. _____	3. _____	↓		
2. _____	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



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

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 _____
(Signature of Parent or Guardian)

Date: _____
(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.