

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

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 LIFE INSURANCE COMPANY OF NEW YORK

Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 1-800-951-6206 • Fax 1-312-351-6930

- IMPORTANT INSTRUCTIONS FOR FILING CLAIM**
1. ONLY THIS ONE FORM IS NECESSARY FOR ALL POLICIES.
 2. IF DISABILITY IS CLAIMED, PLEASE HAVE YOUR EMPLOYER OR SCHOOL COMPLETE STATEMENT ON REVERSE SIDE.
 3. IF MEDICAL OR HOSPITAL BENEFITS ARE CLAIMED, ITEMIZED BILLS MUST BE ATTACHED.

Section A

PLEASE PRINT—DO NOT WRITE

CLAIMANT'S FULL NAME MR. MRS. MISS				SOCIAL SECURITY # (LAST 4 DIGITS)		E-MAIL ADDRESS			
PLEASE LIST OTHER NAMES THAT YOU MAY USE SUCH AS MAIDEN NAME, NICKNAME, ETC.				AREA CODE		HOME PHONE		BUSINESS PHONE	
MAILING ADDRESS (City) (State) (Zip)				POLICY NUMBER(S) a)		FORM NUMBER(S) a)		LAST PAYMENT DATE MO. DAY YR. a) / /	
BIRTH DATE MO. DAY YR. / /		HEIGHT		WEIGHT		b)		b) / /	
Is claimant eligible for Medicaid or a similar state program? <input type="checkbox"/> YES <input type="checkbox"/> NO				NAME OF OTHER INSURANCE CARRIER					
OCCUPATION			DATE LAST WORKED		MONTHLY EARNINGS		ARE YOU FILING CLAIM UNDER WORKERS' COMP. ACT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
EMPLOYER'S NAME AND ADDRESS						ARE YOU RECEIVING SSDI? <input type="checkbox"/> YES <input type="checkbox"/> NO		ARE YOU RECEIVING STATE DISABILITY BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Section B IF CLAIM IS FOR SICKNESS PLEASE COMPLETE	DATE OF FIRST SYMPTOMS MO. DAY YR. / /		HAVE YOU EVER HAD SAME OR SIMILAR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO		MO. DAY YR.	
	NATURE OF SICKNESS					IF YES, GIVE DATE / /

Section C IF CLAIM IS FOR ACCIDENT PLEASE COMPLETE	DATE OF ACCIDENT MO. DAY YR. / /		TIME OF ACCIDENT AM PM		NATURE OF INJURIES	
	PLEASE STATE EXACTLY WHERE YOU WERE WHEN ACCIDENT OCCURRED INCLUDING A DETAILED DESCRIPTION OF HOW ACCIDENT OCCURRED.					

Section D PLEASE COMPLETE FOR BOTH ACCIDENT	HOSPITAL'S NAME AND ADDRESS AND TELEPHONE # AND CONFINEMENT DATES MO. DAY YR. MO. DAY YR. FROM / / TO / /					
	ATTENDING PHYSICIANS' NAMES AND ADDRESSES			DATES OF TREATMENT		

Section E AND SICKNESS CLAIMS	A) TOTAL DISABILITY: BETWEEN WHAT DATES WERE YOU UNABLE TO PERFORM ANY DUTIES?		A) FROM / / THROUGH / /	
	B) DATE RETURNED TO WORK		B) / /	
	C) PARTIAL DISABILITY: BETWEEN WHAT DATES WERE YOU ABLE TO PERFORM ONLY PARTIAL DUTIES?		C) FROM / / THROUGH / /	

WOULD IT BE ALL RIGHT 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 1-800-225-4500. THANK YOU.

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.

DATED: / / SIGNED: **X**
400641R CLAIMANT'S SIGNATURE (If Minor, Parent's Signature) 400641R-09

AUTHORIZATION TO RELEASE INFORMATION

I authorize any hospital, medical practitioner, medically related facility, prescription drug database, insurance company, state and federal government agency, the Internal Revenue Service, employer, consumer reporting agency or the MIB (Medical Information Bureau) to release to Combined Life Insurance Company of New York any information for the purpose of processing a claim. Combined is also authorized to disclose such information to any doctor. This authorization or photocopy shall be valid for the duration of the claim. A copy is available upon request.

DATED: / / SIGNED: **X**
CLAIMANT'S SIGNATURE (If Minor, Parent's Signature)

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 F EMPLOYER'S STATEMENT (IF STUDENT, PLEASE HAVE SCHOOL PRINCIPAL COMPLETE)

EMPLOYEE'S NAME	WORKERS' COMP. CLAIM FILED FOR THIS DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME AND ADDRESS OF COMPENSATION CARRIER
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IF SELF-EMPLOYED, PROVIDE A BRIEF DESCRIPTION OF PRIMARY DUTIES.

TOTAL DISABILITY: BETWEEN WHAT DATES WAS THE EMPLOYEE UNABLE TO PERFORM THEIR DUTIES?	FROM	TO	MO.	DAY	YR.	MO.	DAY	YR.	DATE RETURNED TO WORK (OR SCHOOL)	
									MO. DAY YR.	
PARTIAL DISABILITY: BETWEEN WHAT DATES DID EMPLOYEE PERFORM ONLY PART OF DUTIES?									MO. DAY YR.	
DATE LAST WORKED	MONTHLY EARNINGS									
DATE	TITLE	SIGNATURE						TELEPHONE		

Section G ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME	ADDRESS	CITY-STATE-ZIP CODE	AGE
DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY)			
1. NATURE AND ORIGIN OF:	<input type="checkbox"/> SICKNESS <input type="checkbox"/> INJURY		
		CONFIRMED BY X-RAY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
2. WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?	MO.	DAY	YR.
DATE:			
3. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?	MO.	DAY	YR.
DATE:			
4. HOW DID CONDITION ORIGINATE?			
5. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? (IF "YES," STATE WHEN AND DESCRIBE.)	<input type="checkbox"/> YES <input type="checkbox"/> NO		
6. DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION.			
7. NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY. (DESCRIBE FULLY AND GIVE APPROACH USED IF MORE THAN ONE IS POSSIBLE.)	MO.	DAY	YR.
DATES		CLOSED REDUCTION?	
APPROACH USED		OPEN REDUCTION?	
		METAL FIXATION?	
8. GIVE DATES OF TREATMENT, AND NATURE OF TREATMENT OTHER THAN SURGICAL.	DATES: NATURE OF TREATMENT OFFICE HOME HOSPITAL		
9. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? IF DISCHARGED, GIVE DATE, AND DEGREE OF RECOVERY.	<input type="checkbox"/> YES <input type="checkbox"/> NO DATE: MO. DAY YR. RECOVERED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
10. IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT.	HOSPITAL CITY STATE FROM: MO. DAY YR. TO: MO. DAY YR.		
11. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?	FROM: MO. DAY YR. THROUGH: MO. DAY YR.		
12. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?	FROM: MO. DAY YR. THROUGH: MO. DAY YR.		
13. IF PATIENT DISABLED ON DATE YOU COMPLETE THIS FORM, IS THERE A RETURN TO WORK DATE? (IF "YES," GIVE RETURN TO WORK DATE.)	<input type="checkbox"/> YES <input type="checkbox"/> NO RETURN TO WORK DATE: MO. DAY YR.		

PHYSICIAN'S NAME	SIGNATURE	DEGREE
COMPLETE ADDRESS		
DATE	TELEPHONE	
MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE		
INDIVIDUAL PRACTITIONER'S S.S. NO.		ALL OTHERS - EMPLOYER I.D. NO.
+ + + + +		+ + + + +