

**COMBINED INSURANCE COMPANY OF AMERICA
INSTRUCTIONS FOR FILING ACCIDENT AND HEALTH CLAIMS**

If you are filing for the medical expense benefit only under your accident policy, a claim form may not be needed if the following information is submitted on a timely basis:

- Itemized medical bill(s) clearly indicating the name and address of the patient
- Diagnosis or nature of the injury
- Date and description of how, where and when the accident occurred
- Policy(ies) and form number(s) – **If, in addition to your own policy(ies), you are a dependent under a policy, please include this policy too**

If you are filing for disability and / or hospital confinement, a claim form is required. Help to avoid delays. Please answer all applicable questions on the claim form.

GETTING STARTED

Download the claim form. You can complete the claimant information (first page) online; however, you cannot submit the information electronically. Follow First Page instructions below and upon completion of the first page, print the document (which will be 2 pages). Sign and date the first page including the Authorization to Release Information.

Your doctor must complete the Attending Physician's Statement on the Second Page. And, if you are claiming disability, your employer must complete the Employer's Statement found at the top of the Second Page.

**FIRST PAGE
TO BE COMPLETED BY THE CLAIMANT**

Please be sure to give 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 with a quicker response time.

If filing for loss due to sickness, fill in the section of the form relating to symptoms and diagnosis. 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.

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.

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.

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
TO BE COMPLETED BY EMPLOYER AND DOCTOR**

If gainfully employed outside the home, the 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
CLAIM DEPARTMENT
P O BOX 6700
SCRANTON PA 18505-0700