

# COMBINED INSURANCE COMPANY OF AMERICA

Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700

### 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.	
BIRTH DATE MO. DAY YR.			HEIGHT		WEIGHT		b)		b)		
<b>Is claimant eligible for Medicaid or a similar state program?</b> <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		

<b>Section B</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 .....		

<b>Section C</b> 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.									

<b>Section D</b> 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					

<b>Section E</b> 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 or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

DATED:...../...../..... SIGNED: X.....  
000648-ID CLAIMANT'S SIGNATURE (If Minor, Parent's Signature) 000648-ID-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 Insurance Company of America 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)

**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?	MO. DAY YR. FROM ...../...../..... TO ...../...../..... MO. DAY YR. FROM ...../...../..... TO ...../...../.....	DATE RETURNED TO WORK (OR SCHOOL) MO. DAY YR. ....
PARTIAL DISABILITY: BETWEEN WHAT DATES DID EMPLOYEE PERFORM ONLY PART OF DUTIES?		
DATE LAST WORKED	MONTHLY EARNINGS	

DATE	TITLE	SIGNATURE	TELEPHONE
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**Section G ATTENDING PHYSICIAN'S STATEMENT**

PATIENT'S NAME	ADDRESS	CITY-STATE-ZIP CODE	AGE
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1. NATURE AND ORIGIN OF: <input type="checkbox"/> SICKNESS <input type="checkbox"/> INJURY	<b>DIAGNOSIS</b> (DESCRIBE COMPLICATIONS, IF ANY)  CONFIRMED BY X-RAY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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2. WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?	MO. DAY YR. DATE: ...../...../.....
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3. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?	MO. DAY YR. DATE: ...../...../.....
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4. HOW DID CONDITION ORIGINATE?	
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5. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? (IF "YES," STATE WHEN AND DESCRIBE.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
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6. DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION.	
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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? ..... OPEN REDUCTION? ..... METAL FIXATION? .....
	APPROACH USED: .....	

8. GIVE DATES OF TREATMENT, AND NATURE OF TREATMENT OTHER THAN SURGICAL.	DATES: ..... NATURE OF TREATMENT ..... OFFICE ..... HOME ..... HOSPITAL .....
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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 MO. DAY YR. DATE: ...../...../..... RECOVERED? <input type="checkbox"/> YES <input type="checkbox"/> NO
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10. IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT.	HOSPITAL ..... CITY ..... STATE ..... MO. DAY YR. FROM ...../...../..... TO ...../...../.....
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11. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?	MO. DAY YR. FROM ...../...../..... THROUGH ...../...../.....
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12. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?	MO. DAY YR. FROM ...../...../..... THROUGH ...../...../.....
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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 MO. DAY YR. RETURN TO WORK DATE: ...../...../.....
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PHYSICIAN'S NAME	SIGNATURE	DEGREE
COMPLETE ADDRESS		
DATE	TELEPHONE	
<b>MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE</b>		
INDIVIDUAL PRACTITIONER'S S.S. NO.		ALL OTHERS - EMPLOYER I.D. NO.