

# COMBINED INSURANCE COMPANY OF AMERICA

HOME OFFICE • 5050 BROADWAY, CHICAGO, ILLINOIS 60640

**CLAIM NUMBER**

**NAME ADDRESS**

- IMPORTANT INSTRUCTIONS FOR FILING CLAIM**
1. ONLY THIS ONE FORM IS NECESSARY FOR ALL POLICIES.
  2. IF LOSS OF TIME 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.

PLEASE PRINT—DO NOT WRITE

CLAIMANT'S FULL NAME <small>MR. MRS. MISS</small>				SOCIAL SECURITY #		E-MAIL ADDRESS	
PLEASE LIST OTHER NAMES THAT YOU MAY USE SUCH AS MAIDEN NAME, NICKNAME, ETC.				AREA CODE		HOME PHONE	
ADDRESS (Street and No.) (City) (State) (Zip)				POLICY NUMBER(S)		FORM NUMBER(S)	
				a)		a)	
BIRTH DATE <small>MO. DAY YR.</small>				HEIGHT		WEIGHT	
				b)		b)	
<b>Is claimant eligible for Medicaid or a similar state program?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO				c)		c)	
OCCUPATION		EMPLOYER'S NAME & ADDRESS				ARE YOU ALSO FILING CLAIM UNDER WORKERS' COMP. ACT? <input type="checkbox"/> YES <input type="checkbox"/> NO	

IF YOU HAVE OTHER ACCIDENT, SICKNESS OR HOSPITAL INSURANCE, GIVE COMPANY NAME

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

<b>IF CLAIM IS FOR ACCIDENT</b> PLEASE COMPLETE	DATE OF ACCIDENT <small>MO. DAY YR.</small>	TIME OF ACCIDENT <small>..... AM ..... PM</small>	NATURE OF INJURIES
	PLEASE STATE EXACTLY WHERE YOU WERE WHEN ACCIDENT OCCURRED		
	WHAT WERE YOU DOING WHEN ACCIDENT OCCURRED?		
	PLEASE DESCRIBE IN DETAIL HOW ACCIDENT OCCURRED		

<b>PLEASE COMPLETE FOR BOTH ACCIDENT AND SICKNESS CLAIMS</b>	HOSPITAL'S NAME AND ADDRESS AND CONFINEMENT DATES		<small>MO. DAY YR.</small>	<small>MO. DAY YR.</small>	
			FROM .....	TO .....	
	ATTENDING PHYSICIANS' NAMES AND ADDRESSES		DATES OF TREATMENT		
	A) <b>TOTAL DISABILITY:</b> BETWEEN WHAT DATES WERE YOU UNABLE TO PERFORM ANY DUTIES?		A) FROM..... THROUGH.....		
B) <b>DATE RETURNED TO WORK</b>		B) .....			
C) <b>PARTIAL DISABILITY:</b> 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.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DATED: ..... MO. DAY YR. SIGNED: X ..... CLAIMANT'S SIGNATURE (If Minor, Parent's Signature) R 4/04

## AUTHORIZATION TO RELEASE INFORMATION

I authorize any hospital, medical practitioner, medically related facility, insurance company, employer or consumer reporting agency to release to Combined Insurance Company of America any information concerning my health 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: ..... MO. DAY YR. SIGNED: X ..... CLAIMANT'S SIGNATURE (If Minor, Parent's Signature)

**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			
TOTAL DISABILITY: BETWEEN WHAT DATES DID EMPLOYEE GIVE UP ALL DUTIES?			MO.	DAY	YR.	MO.	DAY	YR.	
FROM...../...../.....			TO...../...../.....			DATE RETURNED TO WORK (OR SCHOOL)			
PARTIAL DISABILITY: BETWEEN WHAT DATES DID EMPLOYEE PERFORM ONLY PART OF DUTIES?			MO.	DAY	YR.	MO.	DAY	YR.	
FROM...../...../.....			TO...../...../.....			DATE...../...../.....			
DATE	TITLE	SIGNATURE					TELEPHONE		

**ATTENDING PHYSICIAN'S STATEMENT**

PATIENT'S NAME		ADDRESS	CITY-STATE-ZIP CODE	AGE
1. NATURE AND ORIGIN OF:		<b>DIAGNOSIS</b> (DESCRIBE COMPLICATIONS, IF ANY)		
<input type="checkbox"/> SICKNESS				
<input type="checkbox"/> INJURY				
2. WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?		MO.	DAY	YR.
DATE...../...../.....		CONFIRMED BY X-RAY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
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 PATIENT HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL.		HOSPITAL	CITY	STATE
FROM...../...../.....		MO.	DAY	YR.
THROUGH...../...../.....		MO.	DAY	YR.
11. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?		MO.	DAY	YR.
FROM...../...../.....		MO.	DAY	YR.
THROUGH...../...../.....		MO.	DAY	YR.
12. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?		MO.	DAY	YR.
FROM...../...../.....		MO.	DAY	YR.
THROUGH...../...../.....		MO.	DAY	YR.
13. WAS PATIENT CONFINED TO THE HOUSE? (IF "YES," GIVE DATES.)		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
FROM...../...../.....		MO.	DAY	YR.
THROUGH...../...../.....		MO.	DAY	YR.

PHYSICIAN'S 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.	