

# 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.

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

PLEASE PRINT--DO NOT WRITE

CLAIMANT'S FULL NAME				SOCIAL SECURITY #	E-MAIL ADDRESS	
MR./ MRS. / MISS				AREA CODE	HOME PHONE	BUSINESS PHONE
Please list other names that you may use such as maiden name, nickname, etc.						
ADDRESS (Street and No.)			(City)	(State)	(Zip)	
POLICY NUMBER(S)			FORM NUMBER(S)		LAST PAYMENT DATE	
a)			a)		a)	
MO.	DAY	YR.	HEIGHT	WEIGHT		
Birth Date			b)	b)	b)	
Is the claimant eligible for Medicaid or similar state program?				c)		c)
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Occupation	Employer's Name & Address			ARE YOU ALSO FILING CLAIM UNDER WORKER'S COMP. ACT?		
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		

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

IF CLAIM IS FOR <b>SICKNESS</b> PLEASE COMPLETE	DATE OF FIRST SYMPTOMS	HAVE YOU EVER HAD SAME OR SIMILAR CONDITION?			
			<input type="checkbox"/> YES	NO <input type="checkbox"/>	IF YES, GIVE DATE .....
NATURE OF SICKNESS					
IF CLAIM IS FOR <b>ACCIDENT</b> PLEASE COMPLETE	DATE OF ACCIDENT	TIME OF ACCIDENT	NATURE OF INJURIES		
			.....AM	.....PM	
	PLEASE STATE EXACTLY WHERE YOU WERE WHEN ACCIDENT OCCURRED				
	WHAT WERE YOU DOING WHEN ACCIDENT OCCURRED?				
PLEASE DESCRIBE IN DETAIL HOW ACCIDENT OCCURRED					
PLEASE COMPLETE FOR BOTH <b>ACCIDENT                  AND                  SICKNESS</b> CLAIMS	HOSPITAL'S NAME AND ADDRESS AND CONFINEMENT DATES				
			FROM .....	TO .....	
	ATTENDING PHYSICIANS' NAMES AND ADDRESSES		DATES OF TREATMENT		
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 .....			
D) IF CONFINED INDOORS, GIVE DATES		D) 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 anytime, please call us at 1-800-225-4500. Thank you.

DATED: .....

SIGNED: X .....  
 CLAIMANT'S SIGNATURE (If Minor, Parent's Signature)

### 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: .....  
 MD-1

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

**ATTENDING PHYSICIAN'S STATEMENT**

PATIENT'S NAME		ADDRESS		CITY-STATE-ZIP CODE		AGE	
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? .....		
					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		MO.	DAY	YR.	RECOVERED? <input type="checkbox"/> YES <input type="checkbox"/> NO
		DATE .....					
10. IF PATIENT HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL.		HOSPITAL		CITY		STATE	
		MO.	DAY	YR.	MO.	DAY	YR.
		FROM .....		TO .....			
11. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?		MO.	DAY	YR.	MO.	DAY	YR.
		FROM .....		THROUGH .....			
12. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?		MO.	DAY	YR.	MO.	DAY	YR.
		FROM .....		THROUGH .....			
13. WAS PATIENT CONFINED TO THE HOUSE? (IF "YES," GIVE DATES.)		<input type="checkbox"/> YES <input type="checkbox"/> NO		MO.	DAY	YR.	MO. DAY YR.
		FROM .....		THROUGH .....			

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.					