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

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

a) Itemized medical bill(s) clearly indicating the name and address of the patient
b) Policy(ies) and form number
c) Diagnosis or nature of the injury
d) Date and description of how, where, and when the accident occurred

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

SIDE ONE
TO BE COMPLETED BY THE CLAIMANT

Please be sure to give your complete name and address. Your payment and/or any correspondence will be mailed to the address unless we are directed to do otherwise.

Write down all policy numbers.

If filing for loss due to sickness, fill in the first section of the form relating to your symptoms and diagnosis.
For loss due to an injury, give us the requested information regarding the accident that caused the injury.

If hospitalized, provide us with the name of the hospital and the dates of admittance and discharge.
Send a copy of the itemized bill(s) for the hospitalization and other medical treatment associated with the loss.

If you were disabled due to the loss, give the exact dates of disability. Please submit the form after you have been disabled for 30 days, or when you return to work, whichever comes first. 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 save processing time in the event that additional information is needed.

SIDE TWO
TO BE COMPLETED BY EMPLOYER AND DOCTOR

If gainfully employed outside the home, the employer must verify your disability. If the Insured is a student, the school principal should complete this section.

The primary physician must complete the remainder of the form, providing the diagnosis, how the condition originated, and the dates of treatment. If treated as an inpatient, the service date must be provided.

Disability dates, both total and partial, must be indicated by the doctor. If you are still disabled at the time the doctor is completing the form, provide his or her complete address and tax number (FID).

For your records, we suggest that you make a copy of the front side of the form and of any bill(s) you submit.
Note the date mailed. Mail the completed form and any enclosures to:

COMBINED INSURANCE COMPANY OF AMERICA
CLAIM DEPARTMENT
5050 NORTH BROADWAY
CHICAGO, IL 60640