

**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

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act which is a crime and may subject such person to criminal and civil penalties.

**Combined Insurance Worksite Solutions**

A unit of Combined Insurance Company of America

CLAIM DEPARTMENT • PO BOX 6700

SCRANTON, PA 18505-0700

**IMPORTANT INSTRUCTIONS FOR FILING CLAIM**

The form must be completed in detail including the employer's statement on reverse side when filing for disability.

PLEASE PRINT - DO NOT WRITE

Claimant's Full Name (Mr. / Mrs. / Miss)					Relationship to Policyholder <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child		Fulltime Student <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please list other names that you may use such as maiden name, nickname, etc.					Social Security # (Last 4 digits)		Area Code Home Phone ( )	
Address (Mailing Address and No.)			City	State	Zip	Policy Number		E-Mail Address
Birth Date	Mo.	Day	Year	Height	Weight	Occupation		
Briefly describe your occupational duties:								
Employer's Name and Complete Address:								
Are you filing claim under Workers' Compensation Act or Social Security Act? If yes, please submit a copy of the award or denial, when received.						Is claimant eligible for Medicaid or a similar state program?		
<input type="checkbox"/> Yes <input type="checkbox"/> No						<input type="checkbox"/> Yes <input type="checkbox"/> No		
If you have other accident-sickness disability insurance give company name, address and monthly benefit amount. (if none, so state)								

<b>If claim is for SICKNESS</b> <i>Please complete</i>	Date of first symptoms Mo. / Day / Year		Have you ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date Mo. / Day / Year						
	Nature of sickness								
<b>If claim is for ACCIDENT</b> <i>Please complete</i>	Date of accident Mo. / Day / Year		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>Please complete for both ACCIDENT AND SICKNESS Claims</b>	Hospital's name and address and telephone #								
	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		Mo. / Day / Year		through		Mo. / Day / Year
B) <b>DATE RETURNED TO WORK:</b>		B)		Mo. / Day / Year					
C) <b>PARTIAL DISABILITY:</b> Between what dates were you able to perform only partial duties?		C) From		Mo. / Day / Year		through		Mo. / Day / Year	

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 1-800-544-9382. THANK YOU.

DATED: \_\_\_\_\_ Mo. / Day / Year SIGNED: X \_\_\_\_\_ CLAIMANT'S SIGNATURE

If your policy is paid with pre-tax dollars, benefits paid may need to be reported to the IRS. Contact your employer regarding reporting requirements.

**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 Insurance 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: \_\_\_\_\_ Mo. / Day / Year SIGNED: X \_\_\_\_\_ CLAIMANT'S SIGNATURE





**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Address: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

This will authorize WORKSITE SOLUTIONS, a unit of COMBINED INSURANCE COMPANY OF AMERICA, PO Box 6700, Scranton, PA 18505-0700 to obtain necessary medical information for the purposes of evaluating my insurance claim. The information to be obtained shall include information from all health care providers, employer, consumer reporting agency, any other insurance company, or the "MIB" (Medical Information Bureau), which is relevant to my loss or condition being evaluated.

The information to be disclosed may include but is not limited to:

- |                            |                      |                     |
|----------------------------|----------------------|---------------------|
| History of Present Illness | Consultant's Reports | Discharge Summary   |
| Operative Reports          | Pathology Reports    | Laboratory Results  |
| Daily Doctor's Notes       | Past Medical History | Previous Admissions |
| X-Ray Reports              | Other (Specify):     |                     |

The information is needed for the following purpose(s):  
Evaluation and processing of my insurance claim

I understand that the information released by this authorization may also include information concerning treatment of physical and mental illness, HIV, alcohol/drug abuse and past medical history.

I understand that upon fulfillment of the above stated purposes, this consent will automatically expire six (6) months following date of signature without any express revocation. I understand I have the right to revoke this authorization at any time, and in order to do so, I must present a written revocation to Combined Insurance Company of America. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy or evaluate my insurance application for coverage.

Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the individual's authorization.

<u>  X  </u> Signature of Patient or Legal Representative	<u>  X  </u> Relationship to Patient (If Legal Representative)
<u>  X  </u> Print Name of Patient or Legal Representative	_____ Date
<u>  X  </u> Signature of Witness	_____ Date

**A photocopy of this authorization may be treated in the same manner as an original.**

Note that no authorization to disclose health information will be processed unless you or your authorized legal representative have signed and dated this form.