Claims Made Easy

For faster claim payment* please submit your claim online at www.CombinedInsurance.com/Claims

FILING A CLAIM BY MAIL

1. Download the claim form
2. Print all six pages of the claim form
3. Complete the first page of the claim form including Section B or C and Sections D and E.
4. Sign and date the first page. There are two areas for your signature marked with an “X” at the bottom of the first page
5. Have your doctor complete the Attending Physician’s Statement on the second page.
6. If you are claiming disability, have your employer complete the Employer’s Statement found at the top of the second page.
7. Sign and date the Fraud Notification on page 5 of the claim form.
8. Send your signed completed claim form with the Physicians Statement, Employer Statement if applicable, and any medical bills or reports that you may have related to your accident or illness to:

   Combined Insurance Claim Department
   PO Box 6700
   Scranton, PA 48585-0700

* on average claims submitted online receive claim payments faster

Combined Insurance Company of America | Chicago, IL
In New York: Combined Life Insurance Company of New York | Latham, NY

COMBINED INSURANCE®
A Chubb Company

C-CLMS-FRM-1-0518

Claims Made Easy

HELPFUL TIPS:

First page (Claimant completes)

Please include 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 us respond quicker.

Accident: 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.

Sickness: If filing for loss due to sickness, fill in the section of the form relating to symptoms and diagnosis.

Hospitalization: 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.

Disability: 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.

Additional: 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 (Employer and Doctor complete)

If you are employed outside the home, your 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 Claims Department
P O Box 6700, Scranton, PA 18505-0700

Remember, you get paid 10 days faster* when you submit a claim online at www.CombinedInsurance.com/Claims

* On average

Combined Insurance Company of America | Chicago, IL
In New York: Combined Life Insurance Company of New York | Latham, NY

COMBINED INSURANCE®
A Chubb Company

COMBINED LIFE INSURANCE COMPANY OF NEW YORK

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)
BIRTH DATE MO. DAY YR. / /	HEIGHT / WEIGHT	LAST PAYMENT DATE MO. DAY YR. a) / /
	b)	b) / /

Is claimant eligible for Medicaid or a similar state program? ☐ YES ☐ NO

NAME OF OTHER INSURANCE CARRIER

OCCUPATION	DATE LAST WORKED	MONTHLY EARNINGS	ARE YOU FILING CLAIM UNDER WORKERS' COMP. ACT? ☐ YES ☐ NO
EMPLOYER'S NAME AND ADDRESS			ARE YOU RECEIVING SSDI? ☐ YES ☐ NO / ARE YOU RECEIVING STATE DISABILITY BENEFITS? ☐ YES ☐ NO

Section B

IF CLAIM IS FOR **SICKNESS** PLEASE COMPLETE

DATE OF FIRST SYMPTOMS MO. DAY YR. / /

HAVE YOU EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO

IF YES, GIVE DATE MO. DAY YR. ...../...../.....

NATURE OF SICKNESS

Section C

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.

Section D

PLEASE COMPLETE FOR BOTH **ACCIDENT**

HOSPITAL'S NAME AND ADDRESS AND TELEPHONE # AND CONFINEMENT DATES

FROM MO. DAY YR. ...../...../..... TO MO. DAY YR. ...../...../.....

ATTENDING PHYSICIANS' NAMES AND ADDRESSES — DATES OF TREATMENT

Section E

AND SICKNESS CLAIMS

A) TOTAL DISABILITY: BETWEEN WHAT DATES WERE YOU UNABLE TO PERFORM ANY DUTIES?

A) FROM MO. DAY YR. ...../...../..... THROUGH MO. DAY YR. ...../...../.....

B) DATE RETURNED TO WORK

B) MO. DAY YR. ...../...../.....

C) PARTIAL DISABILITY: BETWEEN WHAT DATES WERE YOU ABLE TO PERFORM ONLY PARTIAL DUTIES?

C) FROM MO. DAY YR. ...../...../..... THROUGH MO. DAY YR. ...../...../.....

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 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, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

DATED: MO. DAY YR. ...../...../.....

SIGNED: X .....

CLAIMANT'S SIGNATURE (If Minor, Parent's Signature)

400641R

400641R-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 Life Insurance Company of New York 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 YR. ...../...../.....

SIGNED: X .....

CLAIMANT'S SIGNATURE (If Minor, Parent's Signature)

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, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Section F — EMPLOYER'S STATEMENT (IF STUDENT, PLEASE HAVE SCHOOL PRINCIPAL COMPLETE)

EMPLOYEE'S NAME

WORKERS' COMP. CLAIM FILED FOR THIS DISABILITY? ☐ YES NO ☐

NAME AND ADDRESS OF COMPENSATION CARRIER

IF SELF-EMPLOYED, PROVIDE A BRIEF DESCRIPTION OF PRIMARY DUTIES.

TOTAL DISABILITY: BETWEEN WHAT DATES WAS THE EMPLOYEE UNABLE TO PERFORM THEIR DUTIES?
FROM MO. DAY YR. / / TO MO. DAY YR. / /

PARTIAL DISABILITY: BETWEEN WHAT DATES DID EMPLOYEE PERFORM ONLY PART OF DUTIES?
FROM MO. DAY YR. / / TO MO. DAY YR. / /

DATE RETURNED TO WORK (OR SCHOOL)
MO. DAY YR. / /

DATE LAST WORKED

MONTHLY EARNINGS

DATE TITLE SIGNATURE TELEPHONE

Section G — ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME ADDRESS CITY-STATE-ZIP CODE AGE

1. NATURE AND ORIGIN OF: ☐ SICKNESS ☐ INJURY

DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY)

CONFIRMED BY X-RAY? ☐ YES NO ☐

2. WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?
DATE MO. / DAY / YR.

3. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?
DATE MO. / DAY / YR.

4. HOW DID CONDITION ORIGINATE?

5. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? (IF "YES," STATE WHEN AND DESCRIBE.) ☐ YES 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.)
DATES MO. / DAY / YR.
APPROACH USED.
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. ☐ YES NO ☐
DATE MO. / DAY / YR.
RECOVERED? ☐ YES NO ☐

10. IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT.
HOSPITAL CITY STATE
FROM MO. / DAY / YR. TO MO. / DAY / YR.

11. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?
FROM MO. / DAY / YR. THROUGH MO. / DAY / YR.

12. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?
FROM MO. / DAY / YR. THROUGH MO. / DAY / YR.

13. IF PATIENT DISABLED ON DATE YOU COMPLETE THIS FORM, IS THERE A RETURN TO WORK DATE? (IF "YES," GIVE RETURN TO WORK DATE.) ☐ YES NO ☐
RETURN TO WORK DATE: MO. / DAY / YR.

PHYSICIAN'S NAME SIGNATURE DEGREE

COMPLETE ADDRESS

DATE TELEPHONE

MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE

INDIVIDUAL PRACTITIONER'S S.S. NO. ___ ___ + ___ ___ + ___ ___ ___ ___

ALL OTHERS - EMPLOYER I.D. NO. ___ ___ + ___ ___ ___ ___ ___ ___ ___