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 18505-0700

* 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

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COMBINED INSURANCE COMPANY OF AMERICA

Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700 Telephone 1-800-225-4500 Fax 312-351-6930

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	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

	MO. / DAY / YR.	MO. / DAY / YR.
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 / /

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.

THE STATEMENTS MADE BY ME ON THIS CLAIM FORM ARE TRUE AND COMPLETE. I HAVE READ AND UNDERSTAND THE FRAUD LANGUAGE SPECIFIC TO MY STATE, IF ANY, APPEARING ON THE ATTACHED FRAUD NOTIFICATIONS PAGES. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM OR APPLICATION CONTAINING ANY FALSE, INCORRECT OR MISLEADING INFORMATION IS GUILY OF A FELONY OF THE THIRD DEGREE.

DATED: MO. / DAY / YR. /

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

104280-C

104280-C-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 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 / YR. /

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

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.

104280-C

Combined Insurance Company of America

Claim Department • PO Box 6700 • Scranton, PA 18505-0700 Telephone 1-800-225-4500 Fax 312-351-6930

FRAUD NOTIFICATIONS

If you are a resident of or if the policy was issued in one of the following states, we are required to provide you with the following Fraud Warning Notification:

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

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: 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.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the Applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with the intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

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

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

FRAUD NOTIFICATIONS CONTINUED

NEW YORK: 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.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: 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 subjects such person to criminal and civil penalties.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) and not more than ten thousand ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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

ALL OTHER STATES: Any person who knowingly and with intent to defraud any insurance company or other persons, files a 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, subject to criminal prosecution and/or civil penalties.

REQUIRED SIGNATURE OF CLAIMANT

By making claim to these proceeds, I declare that all the answers recorded on this statement are true and complete to the best of my knowledge and belief. I have read the applicable fraud notification statement. I also understand the Company reserves the right to require or obtain further information, should it be deemed necessary.

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

X _____ _____ _____

CLAIMANT'S SIGNATURE | DATED | PLEASE PRINT NAME

I signed on behalf of the claimant, as _____ (relationship). If you are the Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.

Combined Insurance Company of America

Claim Department • PO Box 6700 • Scranton, PA 18505-0700 Telephone 1-800-225-4500 Fax 312-351-6930

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Claim or Policy Number: _____

Name: _____ Doctor's Name: _____

Address: _____ Hospital's Name: _____

Birthdate: _____ /_____ /_____ Adm. ____ /____ /____ Disch. ____ /____ /____

This will authorize 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 any Prescription Drug Database, 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 Report	Discharge Summary
Operative Reports	Pathology Reports	Laboratory Results
Daily Doctor's Notes	Past Medical History	Previous Admissions
X-Ray Reports	Blood/Toxicology	

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 upon fulfillment of the above stated purposes, this consent will automatically expire (6) months following date of signature without any express revocation. I understand and 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/certificate 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 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.

X _____ Date: _____
(Signature of Claimant) (Must be filled in)

X _____ _____
(Signature of Parent or Guardian) (Relationship to Patient if Signed by Guardian)

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