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

COMBINED INSURANCE®
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COMBINED LIFE INSURANCE COMPANY OF NEW YORK

Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 1-800-951-6206 • Fax 1-312-351-6930

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)
		LAST PAYMENT DATE (MO. DAY YR.) 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

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.

Combined Life Insurance Company of New York

Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700 • Telephone 1-800-951-6206 • Fax 312-351-6930

CONSENT TO ELECTRONIC TRANSACTIONS, PAYMENTS AND SIGNATURE

1. Consent to Electronic Transactions

By signing and dating this form, you acknowledge, agree and consent to the use by Combined Life Insurance Company of New York ("Combined") of electronic transactions, electronic signatures, and to the receipt of the electronic version of certain documents and records, including but not limited to policy delivery, acknowledgements, notices (including, without limitation, privacy notices), forms, invoices, explanation of benefits, proof of loss, claims documentation, releases, authorizations to obtain medical records, affidavits, and disclosures, to the extent permitted by law. Electronic documents will be delivered online to your Combined Self-Service Account. You will be notified via email when delivered. This consent unless withdrawn applies to all transactions between you and Combined.

You specifically acknowledge as part of your consent that certain documents delivered electronically will contain confidential information and information regarding your personal financial matters ("Personal Financial Information") and other personally identifiable information; and consent to the delivery of such confidential information, Personal Financial Information and personally identifiable information by electronic means. The consent that you grant shall remain in effect until withdrawn by you.

You specifically acknowledge as part of your consent that we will replace paper delivery of any particular document with electronic delivery at our sole discretion as electronic delivery of particular documents becomes available and are consenting to delivery of documents to you in the following manner: We may send you email transmitting such documents, whether as text in, attachments to, and/or hyperlinks from such emails. Such emails will be sent to the current email address we have on file for you. You are responsible for providing us with a valid email address to which you have regular access and you are responsible for immediately notifying us of any change of email address. Any change to your email address can be completed through our Self-Service portal at https://my.combinedinsurance.com or by calling the Customer Service Department.

You have the right to receive communications from Combined in paper form. You may withdraw this consent at any time. To withdraw your consent, you may call our Customer Service Department at 1-800-951-6206, Monday through Friday between 7:30 am and 6:00 pm CST or go to www.combinedinsurance.com/us-en/contact-us to fill out and submit a General Inquiries form. Your withdrawal will not affect or change in any way the legal effectiveness, validity or enforceability of any documents that were delivered to you electronically before your withdrawal became effective.

To request a paper copy of any document that was originally provided to you electronically, at no charge, please call our Customer Service Department.

2. Consent to Electronic Payment

If you submit a payable claim, Combined may offer you the option to receive your benefit payment electronically via bank transfer into a checking account, transfer into a PayPal account, or transfer to a debit card (as available). Combined will not impose any fees on you for choosing to accept your payment electronically, but your financial institution may impose a fee or charge. By signing and dating this form, you are accepting this offer and consenting to accept benefit payments electronically. Consenting to accept payment electronically is voluntary. Your payments received through electronic transfer may be subject to attachment or garnishment if your account is subject to the same.

If any portion of your claim is payable, you will receive an email with a link to setup an account and provide the routing and account number for the bank or other account where you wish the funds be deposited. If you do not set up an account and provide the account information within three (3) calendar days, we will automatically issue the payment via a check mailed to the address on file.

Unclaimed funds are subject to the applicable laws concerning unclaimed property.

By signing and dating this form, you attest that you are the Principal Insured under the coverage for which your claim was submitted.

3. Consent to Electronic Signature

You also agree that your electronic signature is the legal equivalent of your manual signature on the above listed documents. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise agree, acknowledge, consent, opt-in, or certify to any of the above documents constitutes your signature, acceptance and agreement as if manually signed by you in writing. You agree that no certification authority or other third-party verification is necessary to validate such signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of such signature or any such document. You represent that you will be bound by the terms of this consent. This consent for electronic delivery and signature is effective until withdrawn by you. Doing business electronically will not affect the validity, legal effect or enforceability of any of your transactions with Combined.

Combined Life Insurance Company of New York

Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700 • Telephone 1-800-951-6206 • Fax 312-351-6930

You are responsible for ensuring that neither your software nor your Internet service provider inhibits or interferes with the notices and communications described herein. To ensure delivery of your policy, claim, and/or other documents, the following minimum hardware and system requirements are necessary to sign, print, retain and receive such documents.

Operating Systems	Windows® 7 or 8.1 or MAC
Browsers	Final release versions of Internet Explorer® 9.0 or above (Windows only); Firefox 34 or above (Windows and Mac); Safari™ 5.0 or above (Mac only); Google Chrome 39 or above; Apple iOS 7 or above; Android 4.4 and above
PDF Reader	Acrobat Reader® or similar software may be required to view and print PDF files
Screen Resolution	800 x 600 minimum
Enabled Security Settings	Allow per session cookies

By signing and dating this form, you are confirming that your computer or electronic device meets the system requirements necessary to print, store and receive claims documents electronically and that you may be able to access such documents for future reference.

Print Name

_____

Signature

E-mail Address

_____

Date