

# Claims Made Easy



Your claim is processed ten days faster\* when you submit a claim online at [www.CombinedInsurance.com/Claims](http://www.CombinedInsurance.com/Claims)

## FILING A CLAIM BY MAIL

1. Download the claim form.
2. Print all pages of the claim form.
3. Complete all sections of the Claimant Statement.
4. If you are claiming disability, have your employer complete and sign the **Employer's Statement** found in **SECTION C** on the third page.
5. Have your physician complete **SECTION D**, the **Attending Physician's Statement**, on the fourth page.
6. Review the Fraud Notification for your state on the fifth or sixth page.
7. Sign and date the claim form on the signature line provided at the end of the Fraud Notification page of the claim form. *If you do not sign the Fraud Notification page, we cannot accept your claim submission.*
8. Elect to receive documents electronically and, if your claim is payable, opt in to receive your benefit payment sent electronically via bank transfer into a checking account, transfer into a PayPal account, or transfer to a debit card (as available). To authorize this, please complete and sign the Consent to Electronic Transactions, Payments and Signature document.
9. Sign and date the Authorization to Obtain and Disclose Health Information.
10. Send your signed, completed claim form with the Attending Physician's Statement, Employer Statement, if applicable, and any medical bills or documentation 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 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/certificate 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. You may be requested to provide additional details regarding medical treatment you received within the 5 years prior to your policy effective date.



**Critical Illness:** If filing a critical illness claim, please fill in the date of diagnosis and provide a copy of the pathology report or test results confirming the diagnosis and the level of severity.



**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 the total and/or partial disability. If you are still disabled at the time you submit your claim form, another claim form will be sent to you for continuing disability.



**Wellness:** If filing for wellness/preventative/health screening benefits, please review your policy carefully to ensure the test or procedure is covered under your policy. Do not use the attached claim form if filing for wellness or health screening benefits. Rather use the Health and Wellness claim form which can be found at [www.combinedinsurance.com/forms](http://www.combinedinsurance.com/forms).

**Additional:** Please be sure to sign and date the **Authorization to Release Information**. This will prevent unnecessary delays in the event additional information is needed.

### Third page (Employer completes)

If you are employed outside the home, your employer must verify your disability by completing **Section C - Employer's Statement**. Please note: If the insured is a student, the school principal should complete this section.

### Fourth page (Doctor completes)

Your primary physician must complete **Section D - Attending Physician's Statement** in its entirety. 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 all pages of the completed form and any enclosures to:

**Combined Insurance Claim Department**  
P O Box 6700, Scranton, PA 18505-0700



**Remember, your claim is processed ten days faster\* when you submit a claim online at [www.CombinedInsurance.com/Claims](http://www.CombinedInsurance.com/Claims)**

\* On average

# 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. USE THIS CLAIM FORM FOR ALL CLAIMS EXCEPT FOR WELLNESS/PREVENTATIVE/HEALTH SCREENING BENEFITS.
2. IF DISABILITY IS CLAIMED, PLEASE HAVE YOUR EMPLOYER OR SCHOOL COMPLETE SECTION C, THE EMPLOYER'S STATEMENT.
3. IF MEDICAL OR HOSPITAL BENEFITS ARE CLAIMED, ITEMIZED BILLS MUST BE ATTACHED.

SECTION A CLAIMANT STATEMENT					
PLEASE PRINT					
FIRST NAME	LAST NAME			M.I.	
E-MAIL ADDRESS (Your e-mail address will be updated with this information if different from the e-mail on file)					
PLEASE LIST OTHER NAMES THAT YOU MAY USE SUCH AS MAIDEN NAME, NICKNAME, ETC.		PRIMARY PHONE		SECONDARY PHONE	
MAILING ADDRESS					
CITY				STATE	ZIP
SOCIAL SECURITY # (LAST 4 DIGITS)	BIRTH DATE (MM/DD/YYYY)	HEIGHT (FT/IN)	WEIGHT (LBS)	MALE	FEMALE
POLICY/CERTIFICATE NUMBER(S)					
EMPLOYER'S NAME					
EMPLOYER'S ADDRESS					
CITY				STATE	ZIP
EMPLOYER'S CONTACT NAME		EMPLOYER'S CONTACT PHONE NUMBER		EMPLOYER'S CONTACT FAX NUMBER	
YOUR OCCUPATION					MONTHLY EARNINGS \$
BRIEFLY DESCRIBE YOUR OCCUPATIONAL DUTIES					
HAVE YOU FILED A CLAIM UNDER THE FOLLOWING:			SOCIAL SECURITY ACT?		STATE DISABILITY BENEFITS?
WORKERS' COMPENSATION ACT? YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
IF YOU HAVE OTHER ACCIDENT-SICKNESS DISABILITY INSURANCE, GIVE COMPANY NAME, ADDRESS, AND BENEFIT AMOUNT. (IF NONE, STATE "NONE")					
COMPANY NAME					
ADDRESS					
CITY				STATE	ZIP
BENEFIT AMOUNT					
WEEKLY \$		BI-WEEKLY \$		MONTHLY \$	

Statements made by you on this claim form must be true and complete. Please review the Fraud Warning for your state on the attached Fraud Notification pages. You must sign and date this claim form on the signature line provided on the Fraud Notifications page. *If you do not sign this Fraud Notifications page, we cannot accept your claim submission.*

## SECTION B

## CLAIMANT STATEMENT

PLEASE COMPLETE ALL APPLICABLE SECTIONS BELOW AND SUBMIT DOCUMENTATION TO SUBSTANTIATE COVERED SERVICES CLAIMED UNDER YOUR POLICY.

COMPLETE FOR **ACCIDENT** CLAIM

DATE OF ACCIDENT (MM/DD/YYYY)

INJURIES SUSTAINED

/ /

PLEASE PROVIDE AN EXACT DESCRIPTION OF WHERE YOU WERE WHEN ACCIDENT OCCURRED INCLUDING A DETAILED DESCRIPTION OF WHAT HAPPENED TO YOU.

COMPLETE FOR **SICKNESS** CLAIM

IF FILING FOR CRITICAL ILLNESS BENEFITS, PLEASE ATTACH A COPY OF THE PATHOLOGY REPORT OR TEST(S) THAT CONFIRM THE DIAGNOSIS AND THE SEVERITY OF THE CONDITION.

DATE OF DIAGNOSIS FOR CURRENT SICKNESS  
(MM/DD/YYYY)

SICKNESS DIAGNOSIS IF KNOWN

/ /

PLEASE PROVIDE ADDITIONAL DETAILS INCLUDING SYMPTOMS.

COMPLETE FOR EITHER **ACCIDENT** OR **SICKNESS** CLAIM

FIRST ATTENDING PHYSICIAN'S NAME

ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

FAX NUMBER

INITIAL DATE OF TREATMENT (MM/DD/YYYY)

LAST DATE OF TREATMENT (MM/DD/YYYY)

/ /

/ /

SECOND ATTENDING PHYSICIAN'S NAME

ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

FAX NUMBER

INITIAL DATE OF TREATMENT (MM/DD/YYYY)

LAST DATE OF TREATMENT (MM/DD/YYYY)

/ /

/ /

HOSPITAL NAME

HOSPITAL ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

FAX NUMBER

ADMISSION DATE (MM/DD/YYYY)

DISCHARGE DATE (MM/DD/YYYY)

/ /

/ /

COMPLETE FOR **DISABILITY** CLAIM**TOTAL DISABILITY:**

BETWEEN WHAT DATES WERE YOU UNABLE TO PERFORM ANY DUTIES?

FROM (MM/DD/YYYY)

THROUGH (MM/DD/YYYY)

/ /

/ /

**PARTIAL DISABILITY:**

BETWEEN WHAT DATES WERE YOU ABLE TO PERFORM ONLY PARTIAL DUTIES?

FROM (MM/DD/YYYY)

THROUGH (MM/DD/YYYY)

/ /

/ /

DATE LAST WORKED (MM/DD/YYYY)

DATE RETURNED TO WORK (MM/DD/YYYY)

/ /

/ /

PLEASE HAVE YOUR EMPLOYER COMPLETE AND SIGN SECTION C - EMPLOYER'S STATEMENT FOUND ON THE NEXT PAGE. IF THE INSURED IS A STUDENT, THE SCHOOL PRINCIPAL SHOULD COMPLETE THIS SECTION.

**SECTION C**

**EMPLOYER'S STATEMENT**

IF YOU ARE EMPLOYED OUTSIDE THE HOME, YOUR EMPLOYER MUST VERIFY YOUR DISABILITY BY COMPLETING SECTION C – EMPLOYER'S STATEMENT. PLEASE NOTE: IF THE INSURED IS A STUDENT, THE SCHOOL PRINCIPAL SHOULD COMPLETE THIS SECTION.

EMPLOYEE'S FIRST NAME	LAST NAME	M.I.
-----------------------	-----------	------

CITY	STATE	ZIP
------	-------	-----

PHONE NUMBER	BIRTH DATE (MM/DD/YYYY) / /	CLAIM NUMBER (IF AVAILABLE)
--------------	--------------------------------	-----------------------------

DATE LAST WORKED (MM/DD/YYYY) / /	DATE RETURNED TO WORK (MM/DD/YYYY) / /	FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/>	MONTHLY EARNINGS \$ ,
--------------------------------------	---	---	--------------------------

POLICY NUMBER(S)

EMPLOYEE'S OCCUPATION	DESCRIPTION OF OCCUPATION'S PRIMARY DUTIES
-----------------------	--

WORKERS' COMPENSATION CLAIM FILED FOR THIS DISABILITY? YES  NO  PAID? YES  NO

IF YES PROVIDE THE NAME, ADDRESS AND TELEPHONE NUMBER OF COMPENSATION CARRIER. ALSO, SEND REPORT OF INITIAL INJURY.

NAME

ADDRESS

CITY	STATE	ZIP
------	-------	-----

PHONE NUMBER

PHYSICAL JOB DEMANDS (HH = hours, MM = minutes)

SITTING   PER DAY    WALKING   PER DAY    CLIMBING STAIRS/LADDERS   PER DAY    DRIVING   PER DAY

H H M M                      H H M M                      H H M M                      H H M M

LIFTING:  LESS THAN 15LBS     15 TO 45LBS     MORE THAN 45LBS                      STOOPING/BENDING:  NONE     SELDOM     FREQUENT

<b>TOTAL DISABILITY:</b> BETWEEN WHAT DATES DID THE EMPLOYEE NOT PERFORM ANY JOB DUTIES? FROM (MM/DD/YYYY)                      THROUGH (MM/DD/YYYY) / /    / /	<b>PARTIAL DISABILITY:</b> BETWEEN WHAT DATES DID THE EMPLOYEE ONLY PERFORM PARTIAL JOB DUTIES? FROM (MM/DD/YYYY)                      THROUGH (MM/DD/YYYY) / /    / /
--	---

DURING PARTIAL DISABILITY, DID/WILL EMPLOYEE RECEIVE 75% OR MORE OF HIS PRE-DISABILITY INCOME? YES  NO  IF NO, WHAT PERCENTAGE? \_\_\_\_\_ %

DESCRIPTION OF DUTIES PERFORMED (IF ON PARTIAL DISABILITY)

EMPLOYER CONTACT NAME	CONTACT'S POSITION	DATE (MM/DD/YYYY) / /
-----------------------	--------------------	--------------------------

SIGNATURE	PHONE NUMBER	FAX NUMBER
-----------	--------------	------------

## SECTION D

## ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S FIRST NAME		LAST NAME		M.I.	AGE
ADDRESS					
CITY				STATE	ZIP
NATURE AND ORIGIN OF:		DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY)			
<input type="checkbox"/> SICKNESS					
<input type="checkbox"/> INJURY					
WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN? (MM/DD/YYYY)		WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? (MM/DD/YYYY)		IF SICKNESS, WHEN WAS CONDITION FIRST DIAGNOSED? (MM/DD/YYYY)	
/ /		/ /		/ /	
INDICATE THE DATE AND TYPE OF DIAGNOSTIC TEST USED TO DIAGNOSE CURRENT CONDITION. IF MORE TESTS WERE PERFORMED, PLEASE INCLUDE SUPPORTING DOCUMENTATION. (MM/DD/YYYY)					
/ /					
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/>			(IF "YES", STATE WHEN AND DESCRIBE.) (MM/DD/YYYY)		
/ /					
HOW DID CONDITION ORIGINATE?			DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION.		
NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE(S), IF ANY. (DESCRIBE FULLY)					
DATE (MM/DD/YYYY)		PROCEDURE		OPEN OR CLOSED REDUCTION	
/ /				OPEN <input type="checkbox"/> CLOSED <input type="checkbox"/>	
		NAME OF FACILITY			
GIVE DATES OF TREATMENT AND NATURE OF TREATMENT OTHER THAN SURGICAL.					
OFFICE	DATE (MM/DD/YYYY)	NATURE OF TREATMENT(S)			
	/ /				
	/ /				
	/ /				
		NAME OF FACILITY			
EMERGENCY ROOM (ER)	DATE (MM/DD/YYYY)	NATURE OF TREATMENT			
	/ /				
		NAME OF FACILITY			
URGENT CARE FACILITY	DATE (MM/DD/YYYY)	NATURE OF TREATMENT			
	/ /				
		NAME OF FACILITY			
IS THE PATIENT STILL UNDER YOUR CARE?	HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?		HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? (ONLY ABLE TO WORK PART TIME OR PERFORM PARTIAL JOB DUTIES)?		
YES <input type="checkbox"/> NO <input type="checkbox"/>	FROM (MM/DD/YYYY) THROUGH (MM/DD/YYYY)		FROM (MM/DD/YYYY) THROUGH (MM/DD/YYYY)		
	/ / / /		/ / / /		
PLEASE STATE RESTRICTIONS PLACED ON PATIENT FOR ANY DISABILITY THAT HAS BEEN INDICATED.					
IF PATIENT DISABLED ON DATE YOU COMPLETE THIS FORM, IS THERE A RETURN TO WORK DATE?			RETURN TO WORK DATE (MM/DD/YYYY)		
YES <input type="checkbox"/> NO <input type="checkbox"/> (IF "YES", GIVE RETURN TO WORK DATE.)			/ /		
IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT.			ADMISSION DATE (MM/DD/YYYY)		DISCHARGE DATE (MM/DD/YYYY)
HOSPITAL NAME			/ /		/ /
ADDRESS					
CITY				STATE	ZIP
PHYSICIAN'S NAME		DEGREE		SIGNATURE	
PHONE NUMBER		FAX NUMBER		DATE (MM/DD/YYYY)	
				/ /	
ADDRESS					
CITY				STATE	ZIP
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 Insurance Company of America

Claim Department • P.O. 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.





# Combined Insurance Company of America

Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700 • Telephone 1-800-225-4500 • 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 Insurance Company of America ("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 1-800-225-4500, Monday through Friday between 7:30 am and 6:00 pm CST or go to [www.combinedinsurance.com/us-en/contact-us](http://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 Insurance Company of America

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

## AUTHORIZATION TO OBTAIN AND DISCLOSE 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. I further authorize Combined to rely on this authorization for two years, or as otherwise permitted by law, to disclose information about me for purposes of processing my insurance claims, including assistance with return to work.

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

History of Present Illness  
Operative Reports  
Daily Doctor's Notes  
X-Ray Reports

Consultant's Report  
Pathology Reports  
Past Medical History  
Blood/Toxicology

Discharge Summary  
Laboratory Results  
Previous Admissions

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 expire (24) 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 \_\_\_\_\_  
(Signature of Claimant)

Date: \_\_\_\_\_  
(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.