Claims Made Easy

Your claim is processed ten days faster* when you submit a claim online at 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 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

COMBINED INSURANCE®
A Chubb Company

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.

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

* On average

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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 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:

WORKERS' COMPENSATION ACT? YES ☐ NO ☐ | SOCIAL SECURITY ACT? YES ☐ NO ☐ | STATE DISABILITY BENEFITS? YES ☐ NO ☐

IF YES TO ANY OF THE PRECEDING, PLEASE SUBMIT A COPY OF THE AWARD OR DENIAL LETTER IF RECEIVED.

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. You must sign and date this claim form on the signature line provided on the Fraud Warning page. ***If you do not sign this claim form, 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) / /

DATE LAST WORKED (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 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 ☐	PART TIME ☐	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 H H M M **PER DAY** **WALKING** H H M M **PER DAY** **CLIMBING STAIRS/LADDERS** H H M M **PER DAY** **DRIVING** H H M M **PER DAY**

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

TOTAL DISABILITY:
BETWEEN WHAT DATES DID THE EMPLOYEE NOT PERFORM ANY JOB DUTIES?

FROM (MM/DD/YYYY) / / **THROUGH (MM/DD/YYYY)** / /

PARTIAL DISABILITY:
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: ☐ SICKNESS ☐ INJURY

DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY)

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 ☐ NO ☐

(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

NAME OF FACILITY

OPEN OR CLOSED REDUCTION

OPEN ☐ CLOSED ☐

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? YES ☐ NO ☐

HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?

FROM (MM/DD/YYYY) / / THROUGH (MM/DD/YYYY) / /

HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? (ONLY ABLE TO WORK PART TIME OR PERFORM PARTIAL JOB DUTIES)?

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?

YES ☐ NO ☐ (IF "YES", GIVE RETURN TO WORK DATE.)

RETURN TO WORK DATE (MM/DD/YYYY) / /

IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT.

HOSPITAL NAME

ADMISSION DATE (MM/DD/YYYY) / /

DISCHARGE DATE (MM/DD/YYYY) / /

ADDRESS

CITY | STATE | ZIP

PHYSICIAN'S NAME | DEGREE | SIGNATURE

PHONE NUMBER | FAX NUMBER | DATE (MM/DD/YYYY) / / | STAMP

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 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

REQUIRED SIGNATURE OF CLAIMANT

FRAUD WARNING

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.

X_____ _____ _____

CLAIMANT'S SIGNATURE | DATE | 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.

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

You must sign and date this claim form on the signature line provided on this page. If you do not sign this claim form, we cannot accept your claim submission.

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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

Combined Life Insurance Company of New York

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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 LIFE INSURANCE COMPANY OF NEW YORK, 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	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 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 Life Insurance Company of New York. 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.