COMBINED INSURANCE COMPANY OF AMERICA
INSTRUCTIONS FOR FILING CLAIMS

GETTING STARTED

Follow the Claimant Instructions below to complete the form. Upon completion of the first page you can:

- Mail OR fax the document to the company along with any supporting documentation
- If you are filing for a disability or hospital benefit, Sections C&D must be completed
- If your policy/certificate includes benefits for outpatient treatment, please submit your itemized medical bill(s), clearly indicating the name and address of the patient

CLAIMANT INSTRUCTIONS

Help to avoid delays. Please answer all applicable questions on the claimant's side of the form. Please be sure your answers are clearly stated.

Section A: **Claimant Information: For both Sickness and Accident Claim Filing**

- Claimant's complete name, current mailing address, phone number and birth date
- Policy/Certificate(s) and form number(s) – **If, in addition to your own coverage, you are a dependent under a policy, please include this number as well**
- Employer information (if gainfully employed)

Section B: Details of the injury or illness

- Date and time of the accident and the type of injury sustained **or**
- Date symptoms of the illness first appeared and the nature of the illness/diagnosis
- Provide a description of how, where and when the accident occurred
- Provide the name and addresses of any hospital or doctors that treated you and the dates of treatment
- If applicable, provide dates of disability

Upon completion of the first page, (if you are downloading from the web site the form will be 5 pages), please be sure to sign and date the bottom of the first page. If you reside in a state with state specific fraud language appearing on pages 3 or 4, you must sign the bottom of page 4 and return pages 3 and 4 along with the claim form. Finally, the Authorization to Disclose Health Information (last page) **must be dated and signed**. It is very important that you fill in the name of your provider (physician and/or hospital). If confined to the hospital, enter the admission and discharge dates. **To avoid unnecessary delays, please return all applicable pages.**

EMPLOYER/PROVIDER INSTRUCTIONS
TO BE COMPLETED BY EMPLOYER AND DOCTOR

If you are filing for a disability benefit and/or you were hospitalized, Section C & Section D must be completed

Section C: Employer's Statement

If you are claiming disability and you are gainfully employed outside the home, your employer must verify your disability by completing this section. If the insured is a student, the school principal should complete this section.

Section D: Attending Physician's Statement

If you are claiming disability and/or hospital confinement, your primary physician must complete this section in its entirety including the diagnosis, indication of how the condition originated, dates of treatment including any hospital confinement and/or disability dates. **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 or fax both pages of the completed form and any enclosures to:

COMBINED INSURANCE
CLAIM DEPARTMENT
P O BOX 6700
SCRANTON PA 18505-0700
FAX 1-312-351-6930

Combined Insurance Worksite Solutions
A unit of Combined Insurance Company of America
CLAIM DEPARTMENT • PO BOX 6700
SCRANTON, PA 18505-0700
1-800-544-9382
Fax Number: 1-312-351-6930

IMPORTANT INSTRUCTIONS FOR FILING CLAIM FOR DISABILITY/LOSS OF TIME
The form must be completed in detail including the employer's statement in Section C.

Section A.

PLEASE PRINT—DO NOT WRITE

Claimant's Full Name (Mr. / Mrs. / Miss)	Relationship to Policy/certificateholder	Full time Student
	☐ self ☐ spouse ☐ child	☐ Yes ☐ No
Please list other names that you may use such as maiden name, nickname, etc.	Social Security # (Last 4 digits)	Area Code Home Phone ( )
Address (Mailing Address and No.) City State Zip	Policy/Certificate	E-Mail Address
Mo. Day Year Birth Date / Height / Weight		Occupation

Briefly describe your occupational duties:

Employer's Name and Complete Address:

Are you filing claim under Workers' Compensation Act or Social Security Act? If yes, please submit a copy of the award or denial, when received. ☐ Yes ☐ No	Is claimant eligible for Medicaid or a similar state program? ☐ Yes ☐ No

If you have other accident-sickness disability insurance give company name, address and monthly benefit amount. (if none, so state)

Section B.

Please complete below and attach itemized copies of any related bills, including doctor, emergency room, hospital and motor vehicle incident/accident report. Bills should include diagnosis information from your medical provider.

Date of accident Mo. / Day / Year	Time of accident AM PM	Nature of injuries	Date of first symptoms	Nature of sickness

Please provide an exact description of where you were when accident occurred including a detailed description of what happened to you.

Hospital's name and address and telephone #

Dates of confinement

Attending physicians' names and addresses

Dates of treatment

A) **TOTAL DISABILITY:** Between what dates were you unable to perform any duties? A) From Mo. / Day / Year through Mo. / Day / Year

B) **DATE RETURNED TO WORK:** B) Mo. / Day / Year

C) **PARTIAL DISABILITY:** Between what dates were you able to perform only partial duties? C) From: Mo. / Day / Year through Mo. / Day / Year

WOULD IT BE ALRIGHT 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 1-800-544-9382. Thank you.

DATED: Mo. / Day / Year

SIGNED: X _____
CLAIMANT'S SIGNATURE

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

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, incomplete or misleading information is guilty of a felony of the third degree.

Signature of Claimant X _____ Please Print Name _____

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

Section C.

EMPLOYER'S STATEMENT (necessary for All Disability / Loss of Time claims)

Employee's Name	Date Last Worked	Salary	
		$	☐ Weekly ☐ Monthly

Workers' Compensation claim filed for this disability? ☐ Yes ☐ No — If yes, name, address and telephone number of compensation carrier:

TOTAL DISABILITY:
Between what dates was the employee unable to perform their duties? From Mo. / Day / Year through Mo. / Day / Year

PARTIAL DISABILITY:
Between what dates did employee give up only part of duties? From Mo. / Day / Year through Mo. / Day / Year

During partial disability, did/will employee receive 75% or more of his pre-disability income? ☐ Yes ☐ No

If no, what percentage?_____

Date	Title	Signature	Area Code	Phone Number

Section D.

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name	Address	City, State, Zip Code	Birthdate

1. **Is patient still under your care for this condition?** ☐ Yes ☐ No
   If discharged, give date, and degree of recovery. Date Mo. / Day / Year — Recovered? ☐ Yes ☐ No
2. **How long was or will patient be continuously totally disabled (unable to perform any duties)?** From Mo. / Day / Year through Mo. / Day / Year
2A. **If presently totally disabled, when do you think patient will be able to return to work?** Approximate date: Mo. / Day / Year — Indefinite ☐ Never ☐
3. **How long was or will patient be partially disabled (able to perform only part of duties)?** From Mo. / Day / Year through Mo. / Day / Year

DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

PHONE NUMBER OF REFERRING PHYSICIAN

ADDITIONAL HOSPITALIZATION DATES MM DD YY FROM MM DD YY TO

IS PATIENT'S CONDITION RELATED TO:
EMPLOYMENT ☐ YES ☐ NO AUTO ACCIDENT ☐ YES ☐ NO OTHER ACCIDENT ☐ YES ☐ NO

IF OTHER ACCIDENT, PROVIDE BRIEF DESCRIPTION BELOW.

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM BY LINE)

1. ____ . __ 3. ____ . __
2. ____ . __ 4. ____ . __

	DATE(S) OF SERVICE From MM DD YY	To MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	
1									
2									
3									
4									
5									
6									

FEDERAL TAX I.D. NUMBER:

PHYSICIAN'S NAME

COMPLETE ADDRESS

TELEPHONE

DATE MM DD YY

SIGNING PHYSICIAN CERTIFIES ABOVE DISABILITY DATES, IF ANY.

SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR CREDENTIALS

Combined Insurance Company of America

Claim Department • PO Box 6700 • Scranton, PA 18505-0700 Telephone 1-800-544-9382

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.

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®

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Claim or Policy Number: _____

Name: _____ Doctor's Name: _____

Address: _____ Hospital's Name: _____

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

This will authorize WORKSITE SOLUTIONS, a unit of 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.