COMBINED INSURANCE COMPANY OF AMERICA
INSTRUCTIONS FOR FILING ACCIDENT AND HEALTH CLAIMS

If you are filing for the medical expense benefit only under your accident policy, a claim form may not be needed if the following information is submitted on a timely basis:

- Itemized medical bill(s) clearly indicating the name and address of the patient
- Diagnosis or nature of the injury
- Date and description of how, where and when the accident occurred
- Policy(ies) and form number(s) – **If, in addition to your own policy(ies), you are a dependent under a policy, please include this policy too**

If you are filing for disability and / or hospital confinement, a claim form is required. Help to avoid delays. Please answer all applicable questions on the claim form.

GETTING STARTED

Download the claim form. You can complete the claimant information (first page) online; however, you cannot submit the information electronically. Follow First Page instructions below and upon completion of the first page, print the document (which will be 2 pages). Sign and date the first page including the Authorization to Release Information.

Your doctor must complete the Attending Physician's Statement on the Second Page. And, if you are claiming disability, your employer must complete the Employer's Statement found at the top of the Second Page.

FIRST PAGE
TO BE COMPLETED BY THE CLAIMANT

Please be sure to give 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 with a quicker response time.

If filing for loss due to sickness, fill in the section of the form relating to symptoms and diagnosis. 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.

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.

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.

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
TO BE COMPLETED BY EMPLOYER AND DOCTOR

If gainfully employed outside the home, the 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
CLAIM DEPARTMENT
P O BOX 6700
SCRANTON PA 18505-0700

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.

Combined Insurance Worksite Solutions
A unit of Combined Insurance Company of America
CLAIM DEPARTMENT • PO BOX 6700
SCRANTON, PA 18505-0700

IMPORTANT INSTRUCTIONS FOR FILING CLAIM
The form must be completed in detail including the employer's statement on reverse side when filing for disability.

PLEASE PRINT - DO NOT WRITE

Claimant's Full Name (Mr. / Mrs. / Miss)		Relationship to Policyholder ☐ self ☐ spouse ☐ child	Fulltime Student ☐ 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 Number	E-Mail Address
Birth Date Mo. Day Year	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)

If claim is for SICKNESS Please complete	Date of first symptoms Mo. / Day / Year	Have you ever had same or similar condition? ☐ Yes ☐ No If yes, give date Mo. / Day / Year
	Nature of sickness	
If claim is for ACCIDENT Please complete	Date of accident Mo. / Day / Year	Time of accident AM PM / Nature of injuries
	Please state exactly where you were when accident occurred including a detailed description of how accident occured	
Please complete for both ACCIDENT AND SICKNESS Claims	Hospital's name and address and telephone #	
	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 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 1-800-544-9382. THANK YOU.

DATED: Mo. / Day / Year **SIGNED: X** _____
CLAIMANT'S SIGNATURE

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

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 Insurance 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 / Year **SIGNED: X** _____
CLAIMANT'S SIGNATURE

EMPLOYER'S STATEMENT (necessary for all 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

ATTENDING PHYSICIAN'S STATEMENT

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

1. Nature and origin of: ☐ Sickness ☐ Injury	DIAGNOSIS (Describe complications, if any)
2. When did symptoms first appear or accident happen? If accident include brief description.	Date Mo. / Day / Year
3. When did patient first consult you for this condition?	Date Mo. / Day / Year
4. Has patient ever had same or similar condition? (If "yes" state when and describe)	☐ Yes ☐ No If yes, date Mo. / Day / Year
5. Describe any other disease or infirmity affecting present condition.	
6. Nature of surgical or obstetrical procedure, if any. (Describe fully and give approach used if more than one is possible.)	Date Mo. / Day / Year
7. Give dates of treatment, and nature of treatment other than surgical.	Dates:
8. If hospitalized, give name and address of hospital and dates of confinement.	Hospital City State From Mo. / Day / Year to Mo. / Day / Year
9. Is patient still under your care for this condition? If discharged, give date, and degree of recovery.	☐ Yes ☐ No Date Mo. / Day / Year Recovered? ☐ Yes ☐ No
10. How long was or will patient be continuously totally disabled (unable to perform any duties)?	From Mo. / Day / Year through Mo. / Day / Year
10A. If presently totally disabled, when do you think patient will be able to return to work?	Approximate date: Mo. / Day / Year ☐ Indefinite ☐ Never
11. How long was or will patient be partially disabled (able to perform only part of duties)?	From Mo. / Day / Year through Mo. / Day / Year

Physician's 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 INSURANCE

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name: _____ Policy Number: _____

Address: _____ Claim Number: _____

Birthdate: _____ /_____ /_____

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 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 Reports	Discharge Summary
Operative Reports	Pathology Reports	Laboratory Results
Daily Doctor's Notes	Past Medical History	Previous Admissions
X-Ray Reports	Other (Specify):	

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 that upon fulfillment of the above stated purposes, this consent will automatically expire six (6) months following date of signature without any express revocation. I understand 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 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 any unauthorized 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 _____ X _____
Signature of Patient or Legal Representative | Relationship to Patient (If Legal Representative)

X _____ _____
Print Name of Patient or Legal Representative | Date

X _____ _____
Signature of Witness | Date

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

Note that no authorization to disclose health information will be processed unless you or your authorized legal representative have signed and dated this form.