

## CLAIMANT'S STATEMENT FOR HOSPITAL INDEMNITY CLAIM

Please complete the Claimant's Statement, answering ALL questions on the form. Please complete the Authorization to Release Information and Medical Provider & Employer List. Please submit the completed forms to the above address along with the following information:

- (1) A full copy of the Accident or Police Report and a copy of the Emergency Room Records (including alcohol and drug test results if testing was performed) is required for all Motor Vehicle Accidents.
- (2) Attending Physician's Statement completed by the physician.
- (3) A fully itemized statement of expenses from the Physician, Hospital or Emergency Room. Please include a copy of the Physician's records or a copy of the Admit and Discharge Summary (not the documents given to you when discharged).
- (4) A fully itemized statement of expenses if you received services from any of the following providers:
  - a) Physician's Office, Physician's Clinic Urgent Care Facility.

POLICYHOLDER'S NAME \_\_\_\_\_ POLICY NUMBER(S) \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

CHECK HERE IF NEW ADDRESS  MALE  FEMALE

Employer's Name: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

THIS CLAIM IS ON: INSURED  YOUR SPOUSE  YOUR CHILD  MALE  FEMALE

If the claim is on your spouse or child, please complete the following:

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Policyholder \_\_\_\_\_

What condition are you claiming? \_\_\_\_\_

What date did you first consult the Physician for this condition? \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

1<sup>st</sup> Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

2<sup>nd</sup> Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If you were hospitalized: Date Admitted: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date Discharged: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

Address of Hospital: \_\_\_\_\_

Date Injured: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Time of Accident: \_\_\_\_\_ Where did accident happen? \_\_\_\_\_

Did the accident happen while working on-the-job? Yes  No

Tell us exactly how the accident happened. \_\_\_\_\_

**IMPORTANT NOTICE:** 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.

I certify the above information is true to the best of my knowledge.

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_