

CLAIMANT'S STATEMENT FOR STROKE 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) CT scan, MRI or similar imaging diagnosing the Stroke.
- (2) Clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage.
- (3) Results of the Modified Rankin Scale for Stroke Outcome.
- (4) Copy of the hospital Admit and Discharge Summary (not the documents given to you when discharged).
- (5) Attending Physician's Statement completed by the Neurologist.

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 date were you diagnosed with a stroke? _____

What date did you first consult the Physician for this condition? _____

Primary Physician's Name: _____

Address: _____ Phone: _____

1st Physician's Name: _____

Address: _____ Phone: _____

2nd Physician's Name: _____

Address: _____ Phone: _____

If you were hospitalized: Date Admitted _____ Date Discharged _____

Name of Hospital: _____

Address of Hospital: _____

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 _____