NATIONAL BENEFIT LIFE INSURANCE COMPANY
30-30 47th Avenue, Suite 625, Long Island City, NY 11101-3433 • 800-222-2062

Health Insurance

PATIENT STATEMENT

INSTRUCTIONS:

- **ANSWER ALL QUESTIONS COMPLETELY**
- **ATTACH ALL HOSPITAL BILLS**
- **YOUR DOCTOR MUST COMPLETE AND SIGN THE REVERSE SIDE**

1. Insured's Name: _____Male:____ Female_____ Date of Birth: _____/_____/_____

   Address: _____Apt. No._____

   City: _____State:_____ _____Zip:_____

2. Policy No. _____ Certificate No. _____ Social Security No. _____/_____/_____

3. Claimant's Name, if other than insured: _____Male: ____Female: ____ Date of Birth: ____/____/____

4. Describe illness or injury: _____

5. If accident, give details: _____

6. Date condition first noticed _____/_____/_____ Date doctor first seen _____/_____/_____

7. Have you had the same or similar condition before? Yes ☐ No ☐ If yes, give details:

_____

8. Names and addresses of attending physician(s) _____

_____

9. Name and address of family physician: _____

10. Describe any other illness or injury requiring medical attention in the past 2 years and give name and address of doctor(s) who treated you: Condition: Doctor's name and address:

_____

_____

_____

11. List all other insurance coverage you have:

_____

_____

I authorize any physician, medical practitioner, hospital, clinic other medical care institution, insurance support organization, governmental agency, or insurance company to release any and all medical information and its possession about me or my minor children to National Benefit Life insurance Company or its legal representatives for the length of time of this coverage. Medical information means all information in the possession off or derived from providers of health care regarding the advice, care or treatment of me or my minor children.

I understand that this information will be used by National Benefit Life Insurance Company for the purpose of evaluating my claim for insurance benefits.

I know that I may request a copy of this authorization.

I agree that this authorization shall be valid for the term of the coverage of the policy.

I agree that a photocopy of this authorization shall be as valid as the original.

Claimant sign here: _____ Date: _____/_____/_____
(If a minor, parent or guardian must sign)

Insured sign here: _____ Date: _____/_____/_____

Insured Telephone No.: _____

Return to: **National Benefit Life Insurance Company**
30-30 47th Avenue, Suite 625
Long Island City, NY 11101-3433

1. MEDICARE ☐ *(Medicare #)* MEDICAID ☐ *(Medicaid #)* CHAMPUS ☐ *(Sponsor's SSN)* CHAMPVA ☐ *(VA file #)* GROUP HEALTH PLAN ☐ *(SSN or ID)* FECA BLK LUNG ☐ *(SSN)* OTHER ☐ *(ID)*		**1a. INSURED'S I.D. NUMBER** (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME *(Last Name, First Name, Middle Initial)*	**3. PATIENT'S DATE OF BIRTH** MM DD YY **SEX** M ☐ F ☐	**4. INSURED'S NAME** (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No. Street)	**6. PATIENT RELATIONSHIP TO INSURED** Self ☐ Spouse ☐ Child ☐ Other ☐	**7. INSURED'S ADDRESS** (No., Street)
CITY / **STATE**	**8. PATIENT STATUS** Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	**CITY** / **STATE**
ZIP CODE / **TELEPHONE** (Include Area Code) ( )		**ZIP CODE** / **TELEPHONE** (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	**10. IS PATIENT'S CONDITION RELATED TO:**	**11. INSURED'S POLICY, GROUP OR FECA NUMBER**
a. OTHER INSURED'S POLICY OR GROUP NUMBER	**a. EMPLOYMENT? (CURRENT OR PREVIOUS)** ☐ YES ☐ NO	**a. INSURED'S DATE OF BIRTH** MM DD YY **SEX** M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY **SEX** M ☐ F ☐	**b. AUTO ACCIDENT?** ☐ YES ☐ NO	**b. OTHER CLAIM ID**
c. EMPLOYER'S NAME OR SCHOOL NAME	**c. OTHER ACCIDENT?** ☐ YES ☐ NO	**c. INSURANCE PLAN NAME OR PROGRAM NAME**
d. INSURANCE PLAN NAME OF PROGRAM NAME	**10d. RESERVED FOR LOCAL USE**	**d. IS THERE ANOTHER HEALTH BENEFIT PLAN?** ☐ YES ☐ NO *(If yes, return to and complete item 9a-d)*
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM **12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE** I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. SIGNED: DATE:		**13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE** I authorize payment of medical benefits to the undersigned physician or supplier for services described below: SIGNED:
14. DATE OF CURRENT: MM DD YY ← **ILLNESS** (First symptom) OR **INJURY** (Accident) OR **PREGNANCY** (LMP)	**15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE:** MM DD YY	**16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION:** MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:	**17a.** / **17b. NPI**	**18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		**20. OUTSIDE LAB?** ☐ YES ☐ NO **$CHARGES**
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) **ICD Ind.**_____ A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		**22. MEDICAID RESUBMISION** CODE ORIGINAL REF. NO. **23. PRIOR AUTHORIZATION NUMBER**

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	**B** Place of Service	**C** Type of Service	**D** PROCEDURES, SERVICES OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HCPCS	MODIFIER	**E** DIAGNOSIS CODE	**F** $CHARGES	**G** DAYS OR UNITS	**H** EPSDT FAMILY PLAN	**I** ID QUAL	**J** RENDERING PROVIDER ID #
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	**26. PATIENT'S ACCOUNT NO**	**27. ACCEPT ASSIGNMENT?** (For govt. claims see back) ☐ YES ☐ NO	**28. TOTAL CHARGE** / **29. AMOUNT PAID** / **30.RSVD for NUCC Use**
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signed Date	**32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED** (IF OTHER THAN HOME OR OFFICE)		**33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #:** PIN# GRP#

NUCC Instruction Manual available at: www.nucc.org **APPROVED OMB-0938-1197 FORM 1500 (02-12)**

PLEASE PRINT OR TYPE

NATIONAL BENEFIT LIFE INSURANCE COMPANY
30-30 47th Avenue, Suite 625, Long Island City, NY 11101-3433 • 800- 800-222-2062

PLEASE RETURN THIS FORM WITH YOUR CLAIM

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION

For Use and Disclosure of Protected Health Information

By my signature below:

(1) I authorize National Benefit Life Insurance Company, its affiliates (collectively the "Company"), reinsurers, and authorized representatives, including agents, insurance support organizations and service providers to receive my health information;
(2) I acknowledge that health information may include information about prescription histories, the diagnosis, treatment and prognosis of any physical or mental condition and the use of drugs or alcohol, but not psychotherapy notes;
(3) I authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, Veteran's Administration, government facility, pharmacy, pharmacy benefit manager, insurance company, clearinghouse, or other entity or person ("Providers") to disclose my health information;
(4) I acknowledge that this Authorization may be relied upon to determine my eligibility for insurance, to obtain reinsurance, to administer any claim for insurance benefits or for any other business purpose not otherwise prohibited, including but not limited to any activities related to coverage or benefits or to support the business operations of the Company;
(5) I acknowledge that this Authorization expires two (2) years from the date it is signed;
(6) I acknowledge that I may revoke this Authorization at any time by sending written notice to the Company's address, however, any revocation will not apply retroactively or prevent the Company from contesting a claim for insurance benefits or the policy itself;
(7) I acknowledge that if I refuse to sign this Authorization, a Provider may not refuse to provide treatment or payment for health care services, however, the Company may not be able to process this application or, if coverage is issued, process this claim or make any benefit payments;
(8) I acknowledge that information disclosed pursuant to this Authorization may be re-disclosed and no longer covered by certain federal rules governing privacy of health information; and
(9) I acknowledge that a photographic copy of this Authorization, including a photographic or electronic copy of my signature, is valid as the original and I may receive a copy of this Authorization after it is signed.

Insured: _____Policy Number: _____

Signature of Claimant: _____Date: _____

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Claim Fraud Warning Statements by State

The following statements represent the law in each respective state and are required to be provided by the Company:

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, LOUISIANA, RHODE ISLAND and 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.

CALIFORNIA: For your protection, California law requires the following to appear on this form: 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 files 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to the settlement or award payable form 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 any 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: A 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 injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

INDIANA: Any person who knowingly, and with 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.

MAINE, TENNESSEE, VIRGINIA and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes 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 NH Rev. Stat. Ann. § 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.

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.

OREGON: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application of 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) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are [sic] 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.

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.