

PATIENT STATEMENT

For hospital confinement and surgery

INSTRUCTIONS

- ANSWER ALL QUESTIONS COMPLETELY
- SIGN YOUR NAME BELOW TO AVOID RETURN OF YOUR FORM
- 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 or 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 of initial Doctor visit for condition: ____/____/____

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

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

9. Name and address of family physician: _____

10. Hospital Name: _____

Address: _____ City: _____ State: _____ Zip _____

Date Admitted ____/____/____ Date Discharged ____/____/____

If in Intensive Care Unit give dates, from: ____/____/____ to: ____/____/____

Attach a copy of Hospital Bill

11. Skill Nursing Facility or Rehabilitation Hospital Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date Admitted: ____/____/____ Date Discharged: ____/____/____

Attach a copy of the Skilled Nursing Facility or Rehabilitation Hospital Bill

12. List all other insurance coverage you have with National Benefit:

Policy or Certificate No. (s): _____

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.

I certify that all answers on this form are correct and true, and I am aware of the law of my state concerning Claim Fraud.

Claimant sign here: _____ Date: ____/____/____

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

Insured's Telephone No.: _____

RETURN TO:

NATIONAL BENEFIT LIFE INSURANCE COMPANY
Claims Department
30-30 47th Avenue, Suite 625
Long Island City, New York 11101-3433
1-800-221-2554

ATTENDING PHYSICIAN'S STATEMENT

To be furnished without expense to the Company:

Patient's Name _____ Male: _____ Female: _____ Age: _____

1. a) Primary diagnosis for this confinement: _____
ICD-10 Code(s): _____

b) Indicate the surgical procedure, if any, and date performed: _____

Date(s) _____ CPT Code(s) _____

2. Date of your first consultation: _____

3. Conditions present at first consultation: _____

4. a) In your estimation, how long has patient had the admitting condition prior to your first consultation? _____

b) Was present illness originally diagnosed by you? If so when? _____

c) Name and address of first treating physician (if other than you) _____

5. Patient advised or aware of condition? Yes No On what date? _____

6. Name and address of hospital: _____

Date admitted _____ / _____ / _____ Date Discharged _____ / _____ / _____

Date in ICU _____ / _____ / _____ Date Discharged _____ / _____ / _____

7. Any prior hospitalizations known to you for the same illness? If yes, give dates: _____

8. Any other long-standing disease? If yes, give dates and describe: _____

Date: _____ / _____ / _____ MD Specialty: _____

(Physician Print Name)

Telephone: () _____ Signature: _____

(Physician's Signature)

Street: _____ City: _____ State: _____ Zip Code: _____

**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: _____

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 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 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 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 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.