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

Accident and Health Claim Form

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.

The following statement is made in accordance with Insurance Laws: Any person who knowingly and with intent to defraud any insurance company or other person files an application for 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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: _____

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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: _____