COMBINED
A Chubb Company

Sickness/Disability Claim Form

Combined Insurance Company of America • Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 1-800-544-9382 • Fax 312-351-6930 • my.combinedinsurance.com

Ways to submit your claim:

1. **Online Submission*:** my.combinedinsurance.com
2. **Mail this Completed Form:** Combined Insurance Company of America, Claim Department, P.O. Box 6700, Scranton, PA 18505-0700
3. **Fax this Completed Form:** (312) 351-6930

*Your claim may be processed faster when you submit a claim online.

Sickness/Disability Claim Checklist

- ☐ Section(s) 1 & 2 to be completed by Policyholder and Claimant.
- ☐ Section 3 Employer Statement – To be completed by employer HR representative.
- ☐ Section 4 Attending Physician Statement – To be completed by licensed physician.
- ☐ Section 5 Authorization to Obtain and Disclose Information - to be completed by Claimant, signed, and dated.
- ☐ Section 6: Consent to Electronic Transactions, Payments and Signature - to be completed by Policyholder, including providing phone number, email address, sign, and dated. All pages must be returned if you wish to receive electronic payment.
- ☐ Section(s) 7 & 8 Fraud Warnings to be completed by the Claimant.
- ☐ Submit the completed form using one of the methods shown below.

Note: If your policy/certificate is paid with pre-tax dollars, benefits paid may be reported to the IRS. Contact your Employer regarding reporting requirements.

If you have any questions about the claim process, how to complete this form, or require assistance to log onto the self-service portal, please call 1-800-544-9382.

You may also visit the Policyholder Center to check claim status, download claim forms, or for general policyholder support:
www.combinedinsurance.com/us-en/individuals-families/policyholder-center.html

You MUST sign and date this claim form in all the applicable signature boxes provided. If you do not sign all the applicable signature boxes provided, we cannot accept your claim submission.

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Section 1 – Policy/Certificate Holder Information

First Name | Middle Initial | Last Name | Policy/Certificate Numbers

Date of Birth MM/DD/YYYY | Age | Gender ☐ Male ☐ Female | Social Security No. (last 4 digits)

Address

City | State | Zip

Email | Phone

Section 2 – Claimant Statement

First Name | Middle Initial | Last Name | Date of Birth MM/DD/YYYY | Policy/Certificate Numbers

Last Date Worked MM/DD/YYYY

If hospitalized for this injury or illness, provide the name and address of the hospital.

Address

City | State | Zip

Admitted Date MM/DD/YYYY | Released Date MM/DD/YYYY

Primary (regular) Physician Name | Phone Number

Address

City | State | Zip

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Section 2 – Claimant Statement Continued

If disability resulted from the accident, answer these questions.

Accident Date
/ /
MM/DD/YYYY

Where did the accident occur?

Provide details of how it occurred

Have you ever had the same kind of illness or injury before? ☐ Yes ☐ No

If yes, provide the date, physician's name, phone number, and address.

Date
/ /
MM/DD/YYYY

Physician Name

Phone Number

Address

City

State

Zip

Are you currently working? ☐ Yes ☐ No

HR Contact

HR Contact Phone No.

If yes, provide the date you returned to work (including year)

How many hours are you working?

If no, when do you expect to return to work?

What is the date of your next office visit?

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Section 3 – Employer's Statement, To Be Completed by the Employer

Employee Name | Date of Birth MM/DD/YYYY | Claim Number (if available) | Policy Number (if available)

/ /

☐ Check this box if you are self-employed, then complete and sign this form.

☐ Check this box if you are unemployed. Please provide the last date you worked and prior employer's name then sign this form.

Last Date Worked | Prior Employer's Name

Employment Information/Job Description

Name of Employer/Company | Date of Hire MM/DD/YYYY | Employee's Job Title/Position*

/ /

Prior to inability to work, how many hours a week worked?

Gross Monthly Pay $ | Annual Gross Salary $

*Please include all commissions and bonuses for the 12 months prior to the last date worked.

If you are self-employed, we may require proof of income. We will notify you if additional documentation is required.

*Please attach a copy of the job description or a list of the primary job responsibilities.

Primary Job Responsibilities

Occupational Physical Requirements

Please complete the following section regarding the physical requirements of your employee's occupation by checking the applicable boxes below:

	Constantly greater than 5.5 hours	Frequently 2.5 to 5.5 hours	Occasionally up to 2.5 hours	Never 0 hours
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Stoop	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach Waist Level	☐	☐	☐	☐
Reach Below Waist	☐	☐	☐	☐
Reach Overhead	☐	☐	☐	☐
Handle	☐	☐	☐	☐
Fine Finger	☐	☐	☐	☐
Keyboard/Mouse	☐	☐	☐	☐
Operate Motor Vehicle/ Machinery	☐	☐	☐	☐

Please indicate the maximum level of ability (Sedentary, Light, Medium, Heavy, Very Heavy) to Lift, Carry, Push, and Pull, and specify Right (R), Left (L), or Bilaterally (BL).

	Lift	Carry	Push	Pull
Sedentary = 10 lbs. maximum	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐
Light = 20 lbs. maximum, 10 lbs. frequently	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐
Medium = 50 lbs. maximum, 25 lbs. frequently, up to 10 lbs. constantly	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐
Heavy = 100 lbs. maximum, 50 lbs. frequently, 20 lbs. constantly	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐
Very Heavy = over 100 lbs. occasionally, 50 + lbs. frequently, 20 + lbs. constantly	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐	R ☐ L ☐ BL ☐

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Section 3 – Employer's Statement, To Be Completed by the Employer Continued

Dates Missed Work/Returned to Work

I hereby certify that _____

did not perform any part of his/her work from ___/___/___ (MM/DD/YYYY) through ___/___/___ (MM/DD/YYYY)

What is the expected or estimated return to work date? _____

Has the employee returned to work? ☐ Yes ☐ No

If yes, part time/partial duties date _____ Full time/full duties date ___/___/___ (MM/DD/YYYY)

Did the employee work part time/partial duty? ☐ Yes ☐ No If yes, dates _____

Is part time/partial duty work available? ☐ Yes ☐ No If no, reason _____

When recovered, will he/she resume work? ☐ Yes ☐ No If no, reason _____

Workers' Compensation/Other Disability Coverage

Is this a work-related condition/injury? ☐ Yes ☐ No

If yes, Workers' Compensation begin date ___/___/___ (MM/DD/YYYY) End date ___/___/___ (MM/DD/YYYY)

Workers' Compensation carrier _____ Benefit amount _____ ☐ Monthly ☐ Weekly

Is the employee covered under any other disability policy/coverage through the company? ☐ Yes ☐ No

Other disability insurance carrier* _____ Benefit amount _____ ☐ Monthly ☐ Weekly

Effective Date	Termination Date	Maximum Benefit Period	Elimination Period
___/___/___ (MM/DD/YYYY)	___/___/___ (MM/DD/YYYY)		

Does this policy replace any prior disability policy/coverage through the company? ☐ Yes ☐ No

Prior disability insurance carrier* _____ Benefit amount _____ ☐ Monthly ☐ Weekly

Effective Date	Termination Date	Maximum Benefit Period	Elimination Period
___/___/___ (MM/DD/YYYY)	___/___/___ (MM/DD/YYYY)		

***We may require proof of other disability coverage or prior disability coverage.**

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Section 3 – Employer's Statement, To Be Completed by the Employer Continued

Continued Pay: This is for Group Short-Term Disability and Long-Term Disability Only.

Is the insured receiving continued pay, salary continuation, sick pay, vacation pay, retirement, or disability? ☐ Yes ☐ No

Pay Period from Date MM/DD/YYYY	Through Date MM/DD/YYYY	Amount	Source of Income
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		

Employer Verification

I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this form are true, complete, and correctly recorded.

Signature

Date MM/DD/YYYY / /

Print Name

Title

Company

Phone Number

Address

City

State

Zip Code

Email

Fax Number

Other Comments

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Section 4 – Attending Physician Statement

Claimant Name | Date of Birth (MM/DD/YYYY) | Claim Number (if available) | Policy Number (if available)

Describe the Condition

ICD 9/10 Code | Primary Diagnosis

Other Condition(s)

Nature and origin of condition: ☐ Sickness ☐ Injury

When did the symptoms first appear? / / (MM/DD/YYYY) If applicable, what was the accident date? / / (MM/DD/YYYY)

When did the claimant first consult with you for this condition? / / (MM/DD/YYYY)

Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when?

Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

Pregnancy or Complication of Pregnancy:

Due Date / / (MM/DD/YYYY) Delivery Date / / (MM/DD/YYYY) ☐ Normal Delivery ☐ C-Section ☐ Complications of Pregnancy

Was baby admitted to NICU? ☐ Yes ☐ No If yes, provide dates

Treatment Required

First Consultation / / (MM/DD/YYYY) | Most Recent Consultation / / (MM/DD/YYYY) | Next Consultation / / (MM/DD/YYYY) | Released / / (MM/DD/YYYY)

If sickness, when was the condition first diagnosed? / / (MM/DD/YYYY)

Is/was diagnostic testing performed? ☐ Yes ☐ No

Test(s) Dates

Result: Please include supporting documentation

Is/was a surgical or medical procedure required? ☐ Yes ☐ No Date / / (MM/DD/YYYY) Procedure Code

Procedure

Is/was hospitalization required? ☐ Yes ☐ No Admission Date / / (MM/DD/YYYY) Discharge Date / / (MM/DD/YYYY)

Hospital | City | State

What is the current treatment plan?

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Section 4 – Attending Physician Statement Continued

Treatment Required Continued

Is/was Office/Urgent Care required? ☐ Yes ☐ No Date / / MM/DD/YYYY Name of Facility

Nature of Treatment

Is/was Emergency Room required? ☐ Yes ☐ No Date / / MM/DD/YYYY Name of Facility

Nature of Treatment

The patient is unable to perform their job duties ☐ Yes ☐ No

If yes, please provide the total disability dates from / / MM/DD/YYYY through / / MM/DD/YYYY

When is the patient expected to resume part time/partial duties? / / MM/DD/YYYY Full Time/Full Duties / / MM/DD/YYYY

The restrictions and limitations are ☐ Temporary. If so, how long? ☐ Permanent

What are the current restrictions and limitations?

Attending Physician Verification

I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this form are true, complete, and correctly recorded.

Physician Signature Date / / MM/DD/YYYY Print Name

Specialty Phone Number

Address City State Zip Code

Fax Number Email License Number

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Section 5 – Authorization to Obtain and Disclose Information

Claim or Policy Number (if known)

First Name | Last Name | Date of Birth (MM/DD/YYYY)

Address

City | State | Zip

This will authorize COMBINED INSURANCE COMPANY OF AMERICA & affiliated company ACE Property & Casualty Insurance Company ("Combined"), PO BOX 6700, Scranton, PA, 18505-0700 to obtain necessary medical information for the purposes of evaluating my insurance claim. The information to be obtained shall include information from any Prescription Drug Database, all health care providers, employer, consumer reporting agency, any other insurance company, or the "MIB" (Medical Information Bureau), which is relevant to my loss or condition being evaluated. I further authorize Combined to rely on this authorization for two years, or as otherwise permitted by law, to disclose information about me for purposes of processing my insurance claims, including assistance with return to work.

The information to be disclosed may include but is not limited to:

History of Present Illness	Consultant's Reports	Discharge Summary
Objective Reports	Pathology Reports	Laboratory Results
Daily Doctor's Notes	Past Medical History	Previous Admissions
X-Ray Reports	Blood/Toxicology	

The information is needed for the following purpose(s): Evaluation and processing of my insurance claim

I understand that the information released by this authorization may also include information concerning treatment of physical and mental illness, HIV, alcohol/drug abuse and past medical history.

I understand upon fulfillment of the above stated purposes, this consent will expire (24) months following date of signature without any express revocation. I understand and I have the right to revoke this authorization at any time, and in order to do so, I must present a written revocation to COMBINED INSURANCE COMPANY OF AMERICA & affiliated company ACE Property & Casualty Insurance Company ("Combined"). I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy/certificate or evaluate my insurance application for coverage.

Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by the federal confidentiality rules. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the individual's authorization.

Signature of Claimant | Date (MM/DD/YYYY)

Signature of Parent of Guardian | Relationship to Patient is Signed by Guardian

If signature is provided by Legal Representative, please attach documentation of legal status.

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Section 6 – Consent To Electronic Transactions, Payments And Signature

1. Consent to Electronic Transactions

By signing and dating this form, you acknowledge, agree and consent to the use by Combined Insurance Company of America and affiliated company ACE Property & Casualty Insurance Company ("Combined") of electronic transactions, electronic signatures, and to the receipt of the electronic version of certain documents and records, including but not limited to policy delivery, acknowledgements, notices (including, without limitation, privacy notices), forms, invoices, explanation of benefits, proof of loss, claims documentation, releases, authorizations to obtain medical records, affidavits, and disclosures, to the extent permitted by law. Electronic documents will be delivered online to your Combined Self-Service Account. You will be notified via email when delivered. This consent unless withdrawn applies to all transactions between you and Combined.

You specifically acknowledge as part of your consent that certain documents delivered electronically will contain confidential information and information regarding your personal financial matters ("Personal Financial Information") and other personally identifiable information; and consent to the delivery of such confidential information, Personal Financial Information and personally identifiable information by electronic means. The consent that you grant shall remain in effect until withdrawn by you.

You specifically acknowledge as part of your consent that we will replace paper delivery of any particular document with electronic delivery at our sole discretion as electronic delivery of particular documents becomes available and are consenting to delivery of documents to you in the following manner: We may send you email transmitting such documents, whether as text in, attachments to, and/or hyperlinks from such emails. Such emails will be sent to the current email address we have on file for you. You are responsible for providing us with a valid email address to which you have regular access and you are responsible for immediately notifying us of any change of email address. Any change to your email address can be completed through our Self-Service portal at https://my.combinedinsurance.com or by calling the Customer Service Department.

You have the right to receive communications from Combined in paper form. You may withdraw this consent at any time. To withdraw your consent, you may call our Customer Service Department at 1-800-544-9382, Monday through Friday between 7:30 am and 6:00 pm CST or go to www.combinedinsurance.com/us-en/individuals-families/policyholder-center.html to fill out and submit a General Inquiries form. Your withdrawal will not affect or change in any way the legal effectiveness, validity or enforceability of any documents that were delivered to you electronically before your withdrawal became effective.

To request a paper copy of any document that was originally provided to you electronically, at no charge, please call our Customer Service Department.

Confirmation of Computer or Electronic Device System Requirements

You are responsible for ensuring that neither your software nor your Internet service provider inhibits or interferes with the notices and communications described herein. To ensure delivery of your policy, claim, and/or other documents, the following minimum hardware and system requirements are necessary to sign, print, retain and receive such documents.

Operating Systems	Windows® 7 or 8.1 or MAC
Browsers	Final release versions of Internet Explorer® 9.0 or above (Windows only); Firefox 34 or above (Windows and Mac); Safari™ 5.0 or above (Mac only); Google Chrome 39 or above; Apple iOS 7 or above; Android 4.4 and above
PDF Reader	Acrobat Reader® or similar software may be required to view and print PDF files
Screen Resolution	800 x 600 minimum
Enabled Security Settings	Allow per session cookies

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Section 6 – Consent To Electronic Transactions, Payments And Signature Continued

2. Consent to Electronic Signature

You also agree that your electronic signature is the legal equivalent of your manual signature on the above listed documents. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise agree, acknowledge, consent, opt-in, or certify to any of the above documents constitutes your signature, acceptance and agreement as if manually signed by you in writing. You agree that no certification authority or other third-party verification is necessary to validate such signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of such signature or any such document. You represent that you will be bound by the terms of this consent. This consent for electronic delivery and signature is effective until withdrawn by you. Doing business electronically will not affect the validity, legal effect or enforceability of any of your transactions with Combined.

3. Consent to Electronic Payment

If you submit a payable claim, Combined may offer you the option to receive your benefit payment electronically via bank transfer into a checking account, transfer into a PayPal account, or transfer to a debit card (as available). Combined will not impose any fees on you for choosing to accept your payment electronically, but your financial institution may impose a fee or charge. By signing and dating this form, you are accepting this offer and consenting to accept benefit payments electronically. Consenting to accept payment electronically is voluntary. Your payments received through electronic transfer may be subject to attachment or garnishment if your account is subject to the same.

If any portion of your claim is payable, you will receive an email with a link to setup an account and provide the routing and account number for the bank or other account where you wish the funds be deposited. If you do not set up an account and provide the account information within three (3) calendar days, we will automatically issue the payment via a check mailed to the address on file.

By signing and dating this form, you are confirming that your computer or electronic device meets the system requirements, consenting to do business electronically and consenting to receive claim payments electronically.

PLEASE NOTE: If you wish to receive your claim payment(s) electronically, please return both pages of Section 6.

If you wish to receive a paper check in the mail, DO NOT include Section 6 with your claim submission.

Print Name

Date
/ /
MM/DD/YYYY

Signature

Email Address

Phone Number

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Section 7 – Fraud Warnings

If you are a resident of or if the policy was issued in one of the following states, we are required to provide you with the following Fraud Warning Notification:

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.

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 FORM PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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 policyholder or member for the purpose of defrauding or attempting to defraud the policyholder or member with regard to a 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 an 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: Any 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 defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with the intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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Section 7 – Fraud Warnings Continued

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: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose 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 RSA 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.

PENNSYLVANIA: 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 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) and not more than ten thousand ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be 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.

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Section 7 – Fraud Warnings Continued

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

ALL OTHER STATES: Any person who knowingly and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution and/or civil penalties.

Section 8 – Required Signature of Claimant

NEW YORK FRAUD NOTIFICATION: 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.

REQUIRED SIGNATURE OF CLAIMANT: By making claim to these proceeds, I declare that all the answers recorded on this statement are true and complete to the best of my knowledge and belief. I have read the applicable fraud notification statement. I also understand the Company reserves the right to require or obtain further information, should it be deemed necessary.

Signature of Claimant

Date

/ /

MM/DD/YYYY

Please Print Name

I signed on behalf of the member, as _____ (relationship). If you are the Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority. If your policy/certificate is paid with pre-tax dollars, benefits paid may be reported to the IRS. Contact your Employer regarding reporting requirements.

**You must sign and date this claim form on the signature line provided on this page.
If you do not sign this claim form, we cannot accept your claim submission.**