

CLAIMANT'S STATEMENT FOR HOSPITAL INDEMNITY CLAIM

Please complete the Claimant's Statement, answering ALL questions on the form. Please submit the completed form to the above address along with the following information:

- (1) An Accident or Police Report is required for all Motor Vehicle Accidents.
- (2) A fully itemized statement of expenses (UB92 or HCFA) from the hospital or physician for the services rendered (for example: surgeon, hospital, anesthesia)

POLICYHOLDERS NAME _____ POLICY NO(S) _____

ADDRESS _____

PHONE _____ - _____ - _____ SS# _____ - _____ - _____ DATE OF BIRTH _____ - _____ - _____

Check here if New Address Male Female

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 _____ SS# _____ - _____ - _____

Date of Birth _____ - _____ - _____ Relationship to Policyholder _____

What condition are you claiming? _____

Date Physician was first consulted for this condition _____

Primary Physician's Name: _____

Address _____ Phone No _____ - _____ - _____

1st Physician's Name _____ Phone No _____ - _____ - _____

Address _____

2nd Physician's Name _____ Phone No _____ - _____ - _____

Address _____

If you were hospitalized: Date Admitted _____ - _____ - _____ Date Discharged _____ - _____ - _____

Name of Hospital _____ Phone No _____ - _____ - _____

Address of Hospital _____

Date injured _____ - _____ - _____ Time of Accident _____ Where did accident happen? _____

Tell us exactly how the accident happened _____

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