**COMBINED LIFE INSURANCE COMPANY OF NEW YORK**
**INSTRUCTIONS FOR FILING ACCIDENT AND HEALTH CLAIMS**

If you are filing for the medical expense benefit only under your accident policy, a claim form may not be needed if the following information is submitted on a timely basis:

- Itemized medical bill(s) clearly indicating the name and address of the patient
- Diagnosis or nature of the injury
- Date and description of how, where and when the accident occurred
- Policy(ies) and form number(s) – **If, in addition to your own policy(ies), you are a dependent under a policy, please include this policy too**

If you are filing for disability and / or hospital confinement, a claim form is required. Help to avoid delays. Please answer all applicable questions on the claim form.

GETTING STARTED

Download the claim form. You can complete the claimant information (first page) online; however, you cannot submit the information electronically. Follow First Page instructions below and upon completion of the first page, print the document (which will be 2 pages). Sign and date the first page including the Authorization to Release Information.

Your doctor must complete the Attending Physician's Statement on the Second Page. And, if you are claiming disability, your employer must complete the Employer's Statement found at the top of the Second Page.

**FIRST PAGE**
**TO BE COMPLETED BY THE CLAIMANT**

Please be sure to give your complete name and current mailing address on the claim form as any payment and / or correspondence will be sent to the address indicated on the claim form.

Indicate your policy numbers on the claim form. This will help with a quicker response time.

If filing for loss due to sickness, fill in the section of the form relating to symptoms and diagnosis. For loss due to an accidental bodily injury, please complete the Accident section of the form including a detailed description of how the accident occurred.

If hospitalized, provide us with the name and address of the hospital including the admission and discharge dates. Please also send a copy of the itemized hospital bill including the number of days you were an inpatient.

If you were disabled and have disability coverage, give the exact dates of total and/or partial disability. If you are still disabled at the time you submit the form, another form will be sent to you for continuing disability.

Please be sure to sign and date the Authorization to Release Information located near the bottom of the form. This will prevent unnecessary delays in the event additional information is needed.

**SECOND PAGE**
**TO BE COMPLETED BY EMPLOYER AND DOCTOR**

If gainfully employed outside the home, the employer must verify your disability by completing Section F – Employer's Statement. If the insured is a student, the school principal should complete this section.

The primary physician must complete Section G – Attending Physician's Statement in its entirety including the diagnosis, a description of how the condition originated and dates of treatment. If your claim involves disability and / or hospital confinement, these dates must also be included by your physician. **Failure to make sure that your physician fills in all necessary information on the claim form may cause delays in the processing of your claim.**

For your records, we suggest that you keep a copy of the completed claim form and any bills you submit. Note the date mailed. Mail both pages of the completed form and any enclosures to:

COMBINED INSURANCE
CLAIM DEPARTMENT
P O BOX 6700
SCRANTON PA 18505-0700

# COMBINED LIFE INSURANCE COMPANY OF NEW YORK

**Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700**

IMPORTANT INSTRUCTIONS FOR FILING CLAIM

1. ONLY THIS ONE FORM IS NECESSARY FOR ALL POLICIES.
2. IF DISABILITY IS CLAIMED, PLEASE HAVE YOUR EMPLOYER OR SCHOOL COMPLETE STATEMENT ON REVERSE SIDE.
3. IF MEDICAL OR HOSPITAL BENEFITS ARE CLAIMED, ITEMIZED BILLS MUST BE ATTACHED.

**Section A**

PLEASE PRINT—DO NOT WRITE

| CLAIMANT'S FULL NAME<br>MR.<br>MRS.<br>MISS | SOCIAL SECURITY # (LAST 4 DIGITS) | E-MAIL ADDRESS |
|---|---|---|
| PLEASE LIST OTHER NAMES THAT YOU MAY USE SUCH AS MAIDEN NAME, NICKNAME, ETC. | AREA CODE | HOME PHONE / BUSINESS PHONE |
| MAILING ADDRESS (City) (State) (Zip) | POLICY NUMBER(S)<br>a) | FORM NUMBER(S)<br>a) |
| BIRTH DATE MO. DAY YR. / / | HEIGHT / WEIGHT | LAST PAYMENT DATE MO. DAY YR.<br>a) / / |
| | b) | b) / / |

**Is claimant eligible for Medicaid or a similar state program?** ☐ YES ☐ NO

NAME OF OTHER INSURANCE CARRIER

| OCCUPATION | DATE LAST WORKED | MONTHLY EARNINGS | ARE YOU FILING CLAIM UNDER WORKERS' COMP. ACT? ☐ YES ☐ NO |
|---|---|---|---|
| EMPLOYER'S NAME AND ADDRESS | | | ARE YOU RECEIVING SSDI? ☐ YES ☐ NO / ARE YOU RECEIVING STATE DISABILITY BENEFITS? ☐ YES ☐ NO |

**Section B**

IF CLAIM IS FOR **SICKNESS** PLEASE COMPLETE

DATE OF FIRST SYMPTOMS MO. DAY YR. / /

HAVE YOU EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO

IF YES, GIVE DATE MO. DAY YR. ...../...../.....

NATURE OF SICKNESS

**Section C**

IF CLAIM IS FOR **ACCIDENT** PLEASE COMPLETE

DATE OF ACCIDENT MO. DAY YR. / /

TIME OF ACCIDENT ..... AM ..... PM

NATURE OF INJURIES

PLEASE STATE EXACTLY WHERE YOU WERE WHEN ACCIDENT OCCURRED INCLUDING A DETAILED DESCRIPTION OF HOW ACCIDENT OCCURRED.

**Section D**

PLEASE COMPLETE FOR BOTH **ACCIDENT**

HOSPITAL'S NAME AND ADDRESS AND TELEPHONE # AND CONFINEMENT DATES

FROM MO. DAY YR. ...../...../..... TO MO. DAY YR. ...../...../.....

ATTENDING PHYSICIANS' NAMES AND ADDRESSES — DATES OF TREATMENT

**Section E**

**AND SICKNESS** CLAIMS

**A) TOTAL DISABILITY:** BETWEEN WHAT DATES WERE YOU UNABLE TO PERFORM ANY DUTIES?

A) FROM MO. DAY YR. ...../...../..... THROUGH MO. DAY YR. ...../...../.....

**B) DATE RETURNED TO WORK**

B) MO. DAY YR. ...../...../.....

**C) PARTIAL DISABILITY:** BETWEEN WHAT DATES WERE YOU ABLE TO PERFORM ONLY PARTIAL DUTIES?

C) FROM MO. DAY YR. ...../...../..... THROUGH MO. DAY YR. ...../...../.....

**WOULD IT BE ALL RIGHT IF, DURING THE NEXT YEAR, WE MENTION YOUR CLAIM BENEFITS WHEN TALKING TO PROSPECTIVE POLICYHOLDERS ABOUT OUR CLAIM SERVICE?** ☐ YES ☐ NO

**IF YOU WISH TO DISCONTINUE THIS AUTHORIZATION AT ANY TIME, PLEASE CALL US AT 1-800-225-4500. THANK YOU.**

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.

**DATED:** MO. DAY YR. ...../...../.....

**SIGNED:** X .....

CLAIMANT'S SIGNATURE (If Minor, Parent's Signature)

400641R

400641R-09

## AUTHORIZATION TO RELEASE INFORMATION

**I authorize any hospital, medical practitioner, medically related facility, prescription drug database, insurance company, state and federal government agency, the Internal Revenue Service, employer, consumer reporting agency or the MIB (Medical Information Bureau) to release to Combined Life Insurance Company of New York any information for the purpose of processing a claim. Combined is also authorized to disclose such information to any doctor. This authorization or photocopy shall be valid for the duration of the claim. A copy is available upon request.**

**DATED:** MO. DAY YR. ...../...../.....

**SIGNED:** X .....

CLAIMANT'S SIGNATURE (If Minor, Parent's Signature)

**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.**

## Section F — EMPLOYER'S STATEMENT (IF STUDENT, PLEASE HAVE SCHOOL PRINCIPAL COMPLETE)

EMPLOYEE'S NAME

WORKERS' COMP. CLAIM FILED FOR THIS DISABILITY? ☐ YES NO ☐

NAME AND ADDRESS OF COMPENSATION CARRIER

IF SELF-EMPLOYED, PROVIDE A BRIEF DESCRIPTION OF PRIMARY DUTIES.

TOTAL DISABILITY: BETWEEN WHAT DATES WAS THE EMPLOYEE UNABLE TO PERFORM THEIR DUTIES?
FROM MO. DAY YR. TO MO. DAY YR.

PARTIAL DISABILITY: BETWEEN WHAT DATES DID EMPLOYEE PERFORM ONLY PART OF DUTIES?
FROM MO. DAY YR. TO MO. DAY YR.

DATE RETURNED TO WORK (OR SCHOOL)
MO. DAY YR.

DATE LAST WORKED

MONTHLY EARNINGS

DATE TITLE SIGNATURE TELEPHONE

## Section G — ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME ADDRESS CITY-STATE-ZIP CODE AGE

1. NATURE AND ORIGIN OF: ☐ SICKNESS ☐ INJURY

**DIAGNOSIS** (DESCRIBE COMPLICATIONS, IF ANY)

CONFIRMED BY X-RAY? ☐ YES NO ☐

2. WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?
MO. DAY YR.
DATE

3. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?
MO. DAY YR.
DATE

4. HOW DID CONDITION ORIGINATE?

5. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? (IF "YES," STATE WHEN AND DESCRIBE.) ☐ YES NO ☐

6. DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION.

7. NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY. (DESCRIBE FULLY AND GIVE APPROACH USED IF MORE THAN ONE IS POSSIBLE.)
MO. DAY YR.
DATES
APPROACH USED.
CLOSED REDUCTION?
OPEN REDUCTION?
METAL FIXATION?

8. GIVE DATES OF TREATMENT, AND NATURE OF TREATMENT OTHER THAN SURGICAL.
DATES: NATURE OF TREATMENT
OFFICE
HOME
HOSPITAL

9. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? IF DISCHARGED, GIVE DATE, AND DEGREE OF RECOVERY. ☐ YES NO ☐
MO. DAY YR.
DATE
RECOVERED? ☐ YES NO ☐

10. IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT.
HOSPITAL CITY STATE
MO. DAY YR. MO. DAY YR.
FROM TO

11. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?
MO. DAY YR. MO. DAY YR.
FROM THROUGH

12. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?
MO. DAY YR. MO. DAY YR.
FROM THROUGH

13. IF PATIENT DISABLED ON DATE YOU COMPLETE THIS FORM, IS THERE A RETURN TO WORK DATE? (IF "YES," GIVE RETURN TO WORK DATE.) ☐ YES NO ☐
MO. DAY YR.
RETURN TO WORK DATE:

PHYSICIAN'S NAME SIGNATURE DEGREE

COMPLETE ADDRESS

DATE TELEPHONE

**MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE**

INDIVIDUAL PRACTITIONER'S S.S. NO. ALL OTHERS - EMPLOYER I.D. NO.