NATIONWIDE LIFE INSURANCE COMPANY
NATIONAL CASUALTY COMPANY

**CLAIM FORM** **APPLICATION FOR WEEKLY DISABILITY BENEFITS (To avoid delay please answer all questions)** **GROUP INSURANCE**

## SECTION I TO BE COMPLETED IN FULL BY THE PLAN SPONSOR ORGANIZATION Plan Sponsor Signature Required

***(You may submit proof of membership or certificate of Coverage in place of Plan Sponsor signature)***

1. Policy Number ____________________ 2. Name of Plan Sponsor Organization ____________________ (Group's Name)

3. Plan Sponsor Signature ____________________ 4. Title ____________________

5. Phone ( )__________ 6. Date __________ 7. Name of Patient ____________________ 8. Sex { M { F

9. Address of Patient ________________________________________
( Street) (City) (State) (Zip)

## SECTION II TO BE COMPLETED IN FULL BY THE PATIENT'S DOCTOR

1. Patient's Name ____________________

2. Progress: (a) Has Patient { Recovered? { Improved? { Not Changed? { Retrogressed?

(b) Is Patient { Ambulatory? { Bed confined? { House confined? { Hospital confined?

3. Diagnosis or symptoms ____________________

| 4 Prognosis | His or Her Job? | Any other job?* |
|---|---|---|
| (a) Is patient now capable of performing duties of? | { Yes { No | { Yes { No |

(b) What duties of his or her job is patient incapable of performing? ____________________

| (c) Do you expect a fundamental or marked change in the future? | { Yes { No | { Yes { No |
|---|---|---|
| (1) If Yes, patient should recover sufficiently to perform duties on or about | ____/_____/_______ | _____/______/_______ |

(2) If No, please explain

________________________________________

***for which he or she is reasonably suited or qualified by education, training or experience**

____________________ ____________________ ( ) ____________________
Doctor's Name Degree Telephone Number

________________________________________
Street Address City or Town State Zip

____________________ ____________________
Date Signature

## SECTION III TO BE COMPLETED IN FULL BY PATIENT'S EMPLOYER – PLEASE PRINT

| 1. Employee's Name | 2. Social Security No. | 3. Employer's Disability Insurance Policy No. |
|---|---|---|
| | | |

| 4. Employee's Date of Hire | Employee's Effective Date of Insurance | Last Day Worked | Reason for Stopping Work | Returned to Work On |
|---|---|---|---|---|
| / / | / / | / / | | / / |

| 5. Gross Average Weekly Earnings from | SALARY/WAGES $ | COMMISSIONS $ | OTHER DIRECT JOB INCOME $ |
|---|---|---|---|

6. Will (or has) employee file(d) for Unemployment Compensation or for Disability Benefits provided By any Employer-Employee, Labor Management, or Union Welfare Plan? { Yes { No If "Yes", please specify

| 7. This Employee is Eligible for Salary Contribution | Amount | Duration | 8. This Employee is Eligible for Disability Benefits | Amount | Starting | Duration | Insurance Co. |
|---|---|---|---|---|---|---|---|
| | $ | | | $ | / / | | |

## SECTION III CONTINUED - TO BE COMPLETED IN FULL BY PATIENT'S EMPLOYER – PLEASE PRINT

Employer ________________________________________

Address ________________________________________

Date __________ Signed 7____________________ Title ____________________ Tel No ( ) __________

## SECTION IV – TO BE COMPLETED IN FULL BY THE PATIENT – PLEASE PRINT

| 1. Full Name of Patient | 2. Social Security Number |
|---|---|
| 3. Were you employed at the time | If "Yes", by whom? |

| of your disability? { Yes { No | If "No", Please give reason and name of your last employer | |
|---|---|---|
| 4. Date of Birth / / | Height | 5. Occupation (lists the duties of your occupation at the time of disability if you were employed, or your last job if you were not employed) |
| 6. Sex<br>{ Male<br>{ Female | Weight | |

7. Describe how and where the accident occurred and describe the injuries received or first symptom of your illness

| 8. I (was/have been) unable to work because of this disability starting on:<br>______ /________/__________<br>Month Day Year | 9. I (returned/was able to return/will be able to return to return) to work on a <u>part-time</u> basis on:<br>_______/________/__________<br>Month Day Year | 10. I (returned/was able to return/will be able to return to return) to work on a <u>full-time</u> basis on:<br>_______/________/__________<br>Month Day Year |
|---|---|---|
| 11. Date of accident or the date I first noticed the symptoms of this illness was:<br>_________/__________/__________<br>Month Day Year | 12(a). Is your accident or illness related to your occupation?<br>☐ Yes ☐ No | 12(b). if "YES", explain |

| 13a. Date I was first treated for this accident or illness<br>_________/__________/__________<br>Month Day Year | Treated by | Hospital ____________________<br>Name Address<br>Doctor ____________________<br>Name Address |
|---|---|---|
| 13b. Have you ever had the same or similar condition in the past?<br>☐ Yes ☐ No If "YES", when<br>_____/____/________ | Treated by | Hospital ____________________<br>Name Address<br>Doctor ____________________<br>Name Address |

14 Describe any other income you are receiving or are eligible to receive as a result of your disability: (Examples: Salary Continuance, Employer Disability, Social Security, Workers' Compensation, Unemployment Compensation, State Disability, Pension Disability, Union Welfare Plan, etc).

| Describe Source | Amount of Income | Date of Income | Date Income Ended/Ends |
|---|---|---|---|
| | | | |
| | | | |

I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available regarding either: (a) benefits for which either I, or the minor child for whom I am either parent or guardian, may be entitled to for this claim, or (b) the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or the minor child for whom I am the parent or guardian; to give SPECIAL RISKS HEALTH, Columbus Ohio, or it legal representatives, any and all such information. I AGREE that a photographic copy of this Authorization will be valid as the original. This authorization will remain valid for the term of coverage of the policy.

15. Date _____________ 16. Signature of Patient required__________________________________ 17. Phone ( ) _____________

(Parent or Guardian, if minor)

# CLAIM FILING INSTRUCTIONS
# NOTE TO ORGANIZATIONS AND PATIENT

**Our objective at Special Risks Health is to provide fast and accurate claims service. Listed below are some instructions on claim submissions that, when followed, will assist us in providing this service. All questions must be answered in full for us to process the claim. Failure to do so may result in processing delays.**

## WHEN TO FILE A CLAIM

1. **File the medical claim(s) with the other insurer(s) as soon as possible. Upon receipt of the explanation of benefit statement(s) from your other insurance company(ies) or plan(s) showing payment or denial of claim, submit a copy of the statement(s) along with the completed claim form and copies of all itemized bills to us for processing. An itemized bill normally lists the patient's name, diagnosed condition, treatment dates and charge per treatment, and including the name, address, and federal tax identification number of the provider of service.**

2. **Written notice of claim should be given to us within 30 days after the loss starts.**

3. **Written proof of loss (the completed claim form and supporting documents) should be given to us within 90 days after the loss starts.**

## HOW TO FILE A CLAIM

1. **All questions must be answered in full for us to process the claim.**
2. **Have the patient's doctor complete section II in full.**
3. **Have the patient's employer complete section III.**
4. **The patient (parent or guardian, if minor) must complete section IV in full.**

## WHERE TO FILE A CLAIM

**Specialty Health Claims**
**PO BOX 420**
**Springfield, MA 01101**
**Phone: 1-800-525-8669**
**Web Address: GrouProtector.com**

## State Fraud Notices

**(New York)** 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.

**(Alaska)** A person who knowingly and with intent to injury, defraud, or deceive an insurance company files a claim containing, false, incomplete, or misleading information may be prosecuted under state law.

**(Arkansas)** 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.

**(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.

**(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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant 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.

**(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 benefits if false information materially related to a claim was provided by the applicant.

**(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.

**(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 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.

**(Louisiana)** 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.

**(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.

**(Missouri)** An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

**(Minnesota)** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

## State Fraud Notices Continued

**(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.

**(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)** Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."