NATIONWIDE LIFE INSURANCE COMPANY
NATIONAL CASUALTY COMPANY

CLAIM FORM | VOLUNTEER GROUP INSURANCE | GROUP INSURANCE

NOTE: PLEASE READ THIS BEFORE SUBMITTING CLAIM
PLEASE FILL OUT ALL SECTIONS
-INSTRUCTIONS-

WHEN TO FILE A CLAIM

1. Written notice of claim should be given to us within 30 days after a loss starts.
2. Written proof of loss (completed claim form and supporting documents) should be given to us within 90 days after the loss starts.

HOW TO FILE A CLAIM

1. The Patient (parent or guardian, if minor) must complete the Patient's section (SECTION I) in full.
2. Completion of the assignment section (SECTION II) is optional.
3. The Volunteer Group Certification sections (SECTION III) must be completed and certified by an official of the Volunteer Group. **It is very important that the policy number be shown.**
4. **IF THE CLAIM IS FOR MEDICAL EXPENSE BENEFITS:**
   A. If the Patient is not a volunteer firefighter or volunteer EMT of a volunteer fire company – Please attach itemized bills showing the: (i) name of patient, (ii) diagnosed condition, (iii) date(s) of treatment, (iv) nature of treatment, and (v) charge per treatment as well as the copies of the denial(s).
   B. If the Patient is a volunteer firefighter or a volunteer EMT of a volunteer fire company and some of the medical expenses are denied by our insurance carrier under the Indiana Workers' Compensation or Workers' Occupational Diseases Act - Please attach itemized bills showing the: (i) name of patient, (ii) diagnosed condition, (iii) date(s) of treatment, (iv) nature of treatment, and (v) charge per treatment as well as copies of the denial(s).

WHERE TO FILE A CLAIM

1. Send all completed forms, itemized medical bills, etc. to the address shown below.
2. Any questions regarding filing a claim, benefit payments, etc., should be directed to:

SPECIALTY HEALTH CLAIMS, ATTN CLAIMS UNIT, PO BOX 420, Springfield, MA 01101 PHONE: 1-800-525-8669

SECTION I MUST BE COMPLETED BY THE CLAIMANT/PATIENT

1. Name of Volunteer Group		
2. Name of Patient	3. Birth date / /	4. Social Security No.
5. If the Patient is a minor, name of Patient's parent or guardian		
6. Address of Patient (city, state, zip)		
7. Patient is a(n) { Auxiliary Member { Youth Member { Volunteer Group Member		
8. Activity	9. Supervisor	10. Title

COMPLETE IF ACCIDENT AND/OR DISABILITY (INCLUDING SMOKE INHALATION) IS INVOLVED	11. Date of Accident Time of Accident { AM { PM Dismemberment/Plegia { Fatality {
	12. What injuries were received?
	13. Where did the accident take place?
	How did the accident take place? (Be specific, explain exactly what happened, use additional paper if needed)
	The accident occurred (check, if applicable): { while taking part in the activity referred to in item 8 above, or { during direct travel to or from the activity referred to in item 8 above.
COMPLETE IF CONTAGIOUS OR INFECTIOUS DISEASE (EXCLUDING THE COMMON COLD) OR HEART OR CIRCULATORY MALFUNCTION IS INVOLVED (VOLUNTEER GROUP MEMBERS ONLY)	14. Date of Activity Time of Accident { AM { PM
	15. Nature of disease or malfunction
	16. Describe how and where it was contracted
	17. Date and Time symptoms first appeared { AM { PM
	18. Have you ever had the same condition or similar condition in the past? { Yes { No If "Yes" date of last treatment. Date: / / Treated (by/at):
COMPLETE IF YOU ARE APPLYING FOR WEEKLY INCOME DISABILITY BENEFITS (VOLUNTEER GROUP MEMBERS ONLY)	NOTE: Any weekly income benefit amount payable to you for total or partial disability will be reduced as much as is necessary to keep the total of the amount payable plus your income from other sources (salary continuance, group disability insurance, Workers' Compensation, etc.) from being more than 75% of your gross average weekly earnings from your job. Even though you may be disabled, you should apply for this benefit only if the disability has resulted (or if you were not working – would have resulted) in the actual loss of some or all of your income. If your plan sponsor has elected weekly income benefits and you qualify for them, please check the box below and attach a separate "Application for Weekly Income Disability Benefits" form.

COMPLETE IF YOU ARE APPLYING FOR HOSPITAL INCOME BENEFITS	19. Were you confined as a hospital inpatient as a result of the accident, contagious or infectious disease or heart or circulatory malfunction referred to above? { Yes { No
	20. Please attach the itemized inpatient hospital bills.

21. Is the Patient covered by the employers' health plan or under any other plan? { Yes { No If "Yes", give the name and address of the insurance companies or plans, show type of plan (group, individual, etc.) and attach copies of the expenses paid or payable by them:

Basic coverage with ____ Type of Plan ____

Major medical with ____ Type of Plan ____

22. Is the Patient eligible for Workers' Compensation Benefit? { Yes If "Yes", attach verification of Workers' Compensation payments { No

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, 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.

23. Date ____/_____/_______ 24. Signature of Patient X____ 25. Phone ( ) _______________

(Parent or Guardian, if minor)

SECTION II ASSIGNMENT OF MEDICAL EXPENSE BENEFITS

I Authorize Special Risks to pay medical expense benefits in connection with this claim directly to the doctor, hospital, or other supplier.

26. Date ____/______/______ 27. Signature of Patient ____

(Parent or Guardian, if minor)

SECTION III VOLUNTEER GROUP CERTIFICATION

28. Does the Volunteer Group withhold FICA or Social Security Tax? (Applies only to income received as a volunteer)
{ Yes Amount $______________________ { No

I certify that the above information is correct to the best of my knowledge and belief, that the person named in item 2 is insured by the policy, and that his or her insurance was in effect on the date of the covered activity involved.

29. Date ___/_____/_______ 30. Signed X_______________________________________ 31. Title _______________________________________

32. Policy Number ____	33. Phone ( ) ____

COMPLETE SECTION IV & V IF APPLYING FOR WEEKLY INCOME DISABILTY BENEFITS

SECTION IV TO BE COMPLETED IN FULL BY THE PATIENT'S DOCTOR Note: Applies only to Disability Benefits

34. Name of Patient	35. Date of Illness (first symptom) or Injury (accident)
36. Diagnosis or Symptoms	
37. Date first consulted you for this condition / /	38. Has patient ever had the same or similar symptoms? { Yes { No
39. Date patient able to return to work / /	40. Dates of Total Disability: From / / Through / /

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

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

42. 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

_________/________/_____________ _6 ____

Date Signature

SECTION V TO BE COMPLETED IN FULL BY THE PATIENT'S EMPLOYER		
43. Name of Employee	44. Social Security No.	45. Employer's Disability Insurance Policy Number
46. Employee Date of Hire / /	47. Employee Effective date of coverage / /	48. Last day worked / /
49. Reason for stopping work	50. Returned to work on	51. Occupation at time of disability
52. Work schedule at the time of disability	Days per week	Hours per day

53. Gross Average Weekly Earnings from	Salary/Wages	Commissions	Bonuses	Other Direct Job Income
	$	$	$	$

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

54. This Employee is Eligible for Salary Contribution	Amount	Duration	55. This Employee is Eligible for Disability Benefits	Amount	Starting	Duration	Insurance Co.
	$			$	/ /		

56. Is the Patient eligible for Workers' Compensation benefits? { Yes { No If "Yes", attach verification of Workers' Compensation payments

Employer ____ Address ____

Date ____/___/_______ Signed _________________________________ Title_______________________________ Tel No ( )__________

State Mandated Fraud Notices

(NY) 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.

(AK) 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.

(AR) 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.

(AZ) 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.

(CA) 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.

(CO) 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.

(DC) 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.

(DE) 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.

(FL) 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.

(ID) 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.

(IN) 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.

(KY) 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.

(LA) 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.

(ME) 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.

(MO) 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.

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

(NH) 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.

(NJ) Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

(NM) 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.

(OH) 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.

(OK) 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.

(PA) 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.

(VA) 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.

(WA) 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."