

ACCIDENT & SICKNESS CLAIM FORM

Filing Claim For: (check all that apply)
 Accident
 Cancer
 Heart/Stroke
 Hospitalization
 Sickness, including pregnancy

Instructions:

- Complete Section 1: Claimant's information
- Include copies of all itemized bills related to this claim, or have your doctor complete Section 2: Physician Statement
- Sign and date the claim form at the bottom of this page.

Additional Notes:

- Include a copy of the operative report for any surgery-related claims.
- The processing of your claim may be delayed if all necessary information is not received.

If an accident, complete the following section:

 Date of accident ____ / ____ / ____
 Accident Details _____

 Date of initial medical treatment ____ / ____ / ____
 Was this a work related accident? Yes No
 Covered by workers compensation? Yes No
 If auto accident, was the claimant: Driver Passenger
Include a copy of the incident or police report, if applicable.

IF REQUESTING BENEFITS FOR A DISABILITY POLICY OR AN ACCIDENT POLICY DISABILITY RIDER, the Disability Claim Form must be completed in full and submitted to the address listed on the form. Disability Claims cannot be processed without the Disability Claim Form.

SECTION 1: Claimant's Information			Policyowner's Information		
Last	First	MI	Last	First	MI
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Birth Date: ____ / ____ / ____	Address		<input type="checkbox"/> Check if new address
Relationship to Policyowner: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent			City	State	Zip
Policy No.	Note: If dependent is over the age of 18, provide proof of full-time student status from the accredited institution's registrar.		Social Sec. No. (optional)	Phone No.	Birth Date

SECTION 2: Physician Statement – Have your physician complete this section or attach an itemized bill (HCFA 1500 or UB92)

Name & address of facility where services rendered	
Date patient first consulted you for this condition: ____ / ____ / ____	If pregnant, date of delivery: ____ / ____ / ____ <input type="checkbox"/> Actual <input type="checkbox"/> Expected
Has any other physician ever treated the patient for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, physician's name: _____	Physician's phone: _____
Dates patient hospitalized: ____ / ____ / ____ - ____ / ____ / ____ <input type="checkbox"/> N/A	Anesthesia administered? <input type="checkbox"/> None <input type="checkbox"/> Local <input type="checkbox"/> Non-General <input type="checkbox"/> General

Date(s) of Svc.	Place of Service	Procedure Code	Explain unusual services or circumstances	Diagnosis Code	Charge

Patient Acct No. _____	Tax ID: _____	Total Charge _____
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Physician's Signature _____	Date _____	Phone Number _____
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Physician's Name - printed _____	Address _____
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SECTION 3: Claimant Authorization and Signature

I hereby request and authorize you to furnish to Time Insurance Company or its representatives any and all medical information concerning any illness or injury I may have suffered. (Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same legal authority as the original.

Signature of Claimant (If minor, parent must sign) _____	Relationship to Claimant _____	Date _____
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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.