



Claim Form and Filing Instructions

Claim Filing Requirements

Please read carefully to avoid delaying claim.

- Submit one claim form completed by the policyowner, the claimant and the physician for each accidental injury claim.
- If claiming disability, have the physician's statement and employer's statement entirely completed.
- Please ensure each section is signed and dated by the appropriate individuals.
- Attach copies of all itemized medical bills pertaining to this claim and remit to above address.

Notice: Any incomplete portion of this claim form may result in an unnecessary time delay of claim determination. For a prompt settlement, please be sure to follow the above instructions. Conseco Health Insurance Company reserves the right to request additional information on any claim.

For Assistance Call Toll Free 1-800-541-1225

Part 1 - Policyowner/Certificate Holder Information

Name of Policyowner/ Certificate Holder _____ Address _____ Street City _____ State _____ Zip _____ Check here if new address <input type="checkbox"/> Employer's Name _____	Account Number _____ Phone Number (____) _____ Date of Birth _____ Social Security # _____ Work Telephone (____) _____
---	--

This Authorization Must Be Signed by Patient Before Claim Can Be Processed

I authorize any licensed physician, medical practitioner, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me to give any and all such information to the particular company to which I am submitting a claim, or to its legal representative. I understand that the information obtained by use of this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing Conseco to assist with this purpose.

This authorization includes information about drugs, alcoholism, mental illness, sexually transmitted disease, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

This authorization is valid during the pendency of my claim and shall expire on the date my claim ends. I understand that my authorized representative or I have the right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

Claimant Signature (or Authorized Representative) _____ Date _____

Social Security Number _____

Signed _____ Date _____
Patient (or parent if child) or Executor (or sign as surviving spouse)

Part 2 - Statement of Loss (To Be Completed By Claimant)

- 1. Name of patient: _____
- 2. Date of Birth: _____
- 3. Sex: Male Female
- 4. Social Security Number: _____
- 5. Monthly Income: _____
- 6. Relationship to policyowner/certificate holder: Self Spouse Son Daughter
- 7. Did injury occur on the job? Yes No
- 8. Date of accident/1st symptom: _____
- 9. Where did it happen? _____
- 10. Time: _____
- 11. Has Worker's comp. been filed? Yes No
- 12. Date first consulted physician: _____
- 13. Describe how the injury occurred: _____
- 14. Nature of injury/sickness: _____
- 15. Have you ever had this condition before? Yes No If yes, when? _____
- 16. If hospitalized, when? From _____ To _____ Hospital Name: _____
- 17. Are you covered under any other accident/disability programs? Yes No If yes, please attach a list of company names.
- 18. Are you currently doing anything for wage or profit? Yes No If yes, monthly income: _____
- 19. What specific job duties can't you perform: _____

Part 3 - Physician's Statement (Must Be Completed By Physician's Office)

- Physician Name: _____ Phone Number: _____ ID #: _____
Specialty: _____ Patient's Account Number: _____
Address: _____
Street City State Zip
- 1. Diagnosis: _____
 - 2. Diagnosis Code: _____
 - 3. Was condition due to an accidental injury? Yes No
 - 4. Date accident occurred: _____ Nature of injury: _____
 - 5. Where did injury happen? At work At home Other (Specify) _____
 - 6. When did patient first consult you for this condition? Date: _____ Date of most recent examination: _____
 - 7. Has patient ever had same or similar condition? Yes No If yes, when? _____
 - 8. Describe any other disease or infirmity affecting present condition: _____
 - 9. Please list patient's last known weight: _____ height: _____
 - 10. Referring physician's name and address: _____
 - 11. Was patient under the influence of any intoxicant or narcotic at time of accident? Yes No Did it contribute to the injury? Yes No
If yes, under the direction of a physician? _____
 - 12. Was patient hospitalized solely due to this condition? Yes No Where? _____
Date admitted: _____ Date discharged: _____
 - 13. Was patient disabled? Yes No Total or partial? _____
 - 14. On what dates: From _____ To _____ Return to work: _____
 - 15. *Please list any procedure codes: A) _____ B) _____ C) _____
 - 16. **Please list the objective disability factors (disabling signs & symptoms): _____
 - 17. Is the patient's past medical history on file in your office? Yes No What years are available? _____
- * Please attach a copy of the bill for services you rendered to this patient.**
****If length of this disability period exceeds normal duration for this diagnosis, please attach copies of all supporting documentation.**
- Completed by (print): _____ Position: _____
Physician's Signature: _____ Date: _____

Part 4 - Employer's statement (To Be Completed By Employer)

- 1. Employee's occupation: _____ Major physical tasks performed: _____
 - 2. Give a brief job description (or attach copy to form): _____
 - 3. Does employee pay FICA tax? Yes No If no, does employee pay Medicare tax only? Yes No
 - 4. Dates employee did not work: From _____ To _____
 - 5. Dates employee worked light duty: From _____ To _____
 - 6. Date employee returned to work: _____
 - 7. Did injury occur on the job? Yes No
 - 8. Has worker's compensation been filed? Yes No If yes, worker's comp. carrier: _____
 - 9. If employee has not yet returned to work, is light duty available? Yes No Is employee collecting a full payroll check? Yes No
- Completed by (print): _____ Position: _____ Date: _____
Signature: _____ Phone Number: _____

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

AK, DE, RESIDENTS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ RESIDENTS: 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.

AR RESIDENTS: 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.

CA RESIDENTS: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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 RESIDENTS: 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 RESIDENTS: 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 insurance benefits if false information materially related to a claim was provided by the applicant.

FL RESIDENTS: 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, IN, MN RESIDENTS: A person who knowingly and with intent to defraud or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KS, TX RESIDENTS: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by state or federal law.

KY RESIDENTS: 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, NM RESIDENTS: 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, TN, VA RESIDENTS: 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.

NH RESIDENTS: 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 RESIDENTS: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NY RESIDENTS: 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 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.

OH, OR RESIDENTS: 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 RESIDENTS: 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 RESIDENTS: 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.

PR RESIDENTS: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.