HOSPITAL INDEMNITY CLAIM FORM

INSTRUCTIONS:

— The Administrator will complete the Policyholder Statement section. You should complete all remaining sections and sign the Member Certification. ***COMPLETION*** *of the entire form speeds claims processing.*
— Please make sure that you sign the Authorization for Release of Information on the reverse side of this claim.
— Have your provider of service complete the Physician or Supplier Information Section on the reverse side of this form.

MAIL COMPLETED FORM AND ANY ITEMIZED BILLS TO:
MASS BENEFITS CONSULTANTS, INC
P. O. BOX 828
ANNANDALE, VA 22003-0828
(800) 221-3083

CLAIM PROCESSING INFORMATION (COMPLETED BY MEMBER)

▶ MEMBER'S LAST NAME: FIRST NAME: INITIAL:

STREET ADDRESS:

CITY: STATE: ZIP CODE:

DAYTIME TELEPHONE NUMBER:
( ) —

▶ DATE OF BIRTH: MONTH___DAY___YEAR_____ ▶SEX: ☐MALE ☐FEMALE

▶ MARITAL STATUS: ☐SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED

▶ ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED THROUGH ANY OTHER PLANS WHICH PROVIDE HOSPITAL INDEMNITY BENEFITS?

☐YES ☐NO
IF YES, PROVIDE INFORMATION REQUESTED BELOW:

OTHER CARRIER'S NAME:

ADDRESS:

TELEPHONE NUMBER:

NAME OF COVERED PERSON:

PLAN NUMBER:

▶ ON WHAT DATE DID SYMPTOMS FIRST APPEAR?
MONTH_____ DAY_____ YEAR_____

▶ SOCIAL SECURITY NUMBER
_____/_____/_____

▶ NAME AND ADDRESSES OF PHYSICIANS AND/OR MEDICAL FACILITIES TREATING THE PATIENT:

▶ NAME AND ADDRESS OF HOSPITAL WHERE CONFINED:

▶ DATES OF HOSPITAL CONFINEMENT:
FROM_____ TO_____
FROM_____ TO_____
FROM_____ TO_____

▶ NATURE OF SICKNESS OR INJURY:

▶ ON WHAT DATE DID THE PATIENT FIRST CONSULT OR RECEIVE MEDICAL TREATMENT FROM A PHYSICIAN FOR THIS ILLNESS OR ACCIDENT?

MONTH_____ DAY_____ YEAR_____

PATIENT INFORMATION

▶ LAST NAME: FIRST NAME: INITIAL:

▶ STREET ADDRESS: *(IF DIFFERENT FROM MEMBER'S ADDRESS)*

CITY: STATE: ZIP CODE:

▶ PATIENT'S RELATIONSHIP TO MEMBER:

☐SPOUSE ☐CHILD ☐STEPCHILD ☐OTHER _____

▶ PATIENT SEX: ☐MALE ☐FEMALE

▶ DATE OF BIRTH: MONTH_____DAY_____YEAR_____

▶ SOCIAL SECURITY NUMBER _____/_____/_____

▶ IF CLAIM IS FOR DEPENDENT CHILD, WHEN CHARGES WERE INCURRED, WAS CHILD:

MARRIED? ☐YES ☐NO
EMPLOYED? ☐YES ☐ NO
IN THE MILITARY? ☐ YES ☐ NO
FEDERAL EMPLOYEE? ☐ YES ☐ NO

MEMBER CERTIFICATION

I CERTIFY: I HAVE READ AND UNDERSTAND THE FRAUD STATEMENT THAT IS APPLICABLE TO THE STATE IN WHICH I RESIDE. ANY PERSON WHO KNOWINGLY AND WITH THE 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.

New York Residents: Any person who knowingly and with the 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.

I CERTIFY THAT THE INFORMATION SHOWN ABOVE IS COMPLETE AND ACCURATE.

MEMBER'S SIGNATURE: _____ DATE: _____
(SIGNATURE OF DEPENDENT SPOUSE IS NOT ACCEPTABLE)

POLICYHOLDER STATEMENT (COMPLETED BY ADMINISTRATOR)

▶ MEMBER'S LAST NAME: FIRST NAME: INITIAL:

SEX: ☐MALE ☐FEMALE DATE OF BIRTH: MONTH_____DAY____YEAR_____

▶ MEMBER'S INSURANCE EFFECTIVE DATE: MONTH_____ DAY____YEAR_____

▶ MEMBER'S PAID TO DATE: MONTH_____ DAY____YEAR_____

▶ CERTIFICATE HOLDER ID:_____

▶ NAME OF POLICYHOLDER:_____

▶ I HEREBY CERTIFY THAT THE ABOVE FACTS ARE TRUE TO THE BEST OF MY KNOWLEDGE

▶ GROUP POLICY NUMBER: **G-29162**

AMOUNT OF DAILY BENEFIT:

$_____

▶ CANCER/ICU BENFIT: ☐YES ☐NO

▶ SURGICAL BENEFIT: ☐YES ☐NO

▶ (INDICATE APPLICABLE BENEFIT):
☐ $1000 ☐ $2000

▶ DOES THIS MEMBER HAVE DEPENDENT'S INSURANCE?☐YES ☐NO

IF YES, ☐ SPOUSE ☐ CHILDREN

▶ DEPENDENT'S INSURANCE EFFECTIVE DATE: MO_____ DY_____ YR_____
(IF APPLICABLE)

▶ AMOUNT OF DAILY BENEFIT (DEPENDENT): $_____

▶DEPENDENT'S PAID TO DATE: MO_____ DY_____ YR_____

DATE SIGNED: _____ BY: _____

22039 (6/11) (AUTHORIZED REPRESENTATIVE) (TITLE)

AUTHORIZATION FOR RELEASE OF INFORMATION (COMPLETED BY PATIENT)

TO: All providers of medical services and supplies, employers, insurance institutions and other organizations.

I authorize release to New York Life Insurance Company and any independent claim administrators, consulting health professionals and utilization review organizations with whom New York Life has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits.

This authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this authorization at any time by notifying the Administrator in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person has already disclosed or collected information or taken other action in reliance on it. The information New York Life obtains through this authorization may become subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

A photocopy of this authorization and request form shall be as valid as the original. I know that I may request a copy of this authorization.

_____ _____

PATIENT'S SIGNATURE (PARENT'S/GUARDIAN IF MINOR) **DATE**

PHYSICIAN OR SUPPLIER INFORMATION (MUST BE COMPLETED IN FULL BY PROVIDER OF SERVICE)

DATE OF CURRENT:
MO DY YR
_____/ _____/ _____

☐ ILLNESS (FIRST SYMPTOM) OR
☐ INJURY (ACCIDENT) OR
☐ PREGNANCY (LMP)

DATE FIRST CONSULTED YOU FOR THIS CONDITION:
MO DY YR
_____/ _____/ _____

HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐YES ☐NO
IF YES, GIVE FIRST DATE: MO DY YR
_____/ _____/ _____

HOSPITALIZATION DATES RELATED TO CURRENT SERVICES:
MO DY YR MO DY YR
FROM _____/ _____/ _____ THROUGH _____/ _____/ _____

NAME OF REFERRING PHYSICIAN

_____

_____

_____

PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP & PHONE #

_____

_____

_____

_____

_____
FEDERAL TAX I.D. NUMBER SSN EIN

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:

1. _____

2. _____

3. _____

4. _____

IS CONDITION DUE TO PREGNANCY? ☐YES ☐NO

IF YES, GIVE APPROXIMATE DATE PREGNANCY COMMENCED.
MO DY YR
_____/ _____/ _____

SIGNATURE _____DATE _____

PLEASE REMEMBER TO ATTACH YOUR HOSPITAL BILL TO THIS CLAIM FORM AND MAIL TO THE ADDRESS ON THE REVERSE SIDE OF THIS FORM.