STATEMENT OF CLAIM - HOSPITAL INDEMNITY OR CANCER INSURANCE

Name of Member	Social Security Number	Sex ☐ Male ☐ Female	☐ Single ☐ Married ☐ ________	Date of Birth

Address	City	State	Zip Code	Is this a New Address? ☐ Yes ☐ No

Name of Patient	Social Security Number	Date of Birth	Phone Number ( )

Relationship to Member ☐ Self ☐ Child ☐ Spouse ☐ Other___________	Is Patient a full time student? ☐ Yes ☐ No If Yes, name of School: ___________________________________

Name of Association (if applicable)	Policy Number	Certificate Number

Nature of illness or accident - describe (if accident provide accident report or supporting documents)	Date of Accident

Have You Claimed Benefits for this Condition Previously? ☐ Yes ☐ No **If Yes, when**

Give Name and Address Of Any Physicians Who Were Consulted For This Condition

Name	Address
Name	Address

Warning and Notice*:* Any person who knowingly and with intent to defraud, injure or deceive an insurance company or other person files a statement of claim or application containing any materially false or misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a crime and may be subject to civil penalties, fines, and/or imprisonment.
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 with the Department of Regulatory Agencies.
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.
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 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
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.

Authorization: I authorize any doctor, hospital, or other medical or medically related facility, treatment center, recovery center, insurance company, consumer reporting agency, employer, Social Security Administration or any other organization or person having any knowledge of the patient, employee or deceased, including financial institutions, to give Monumental Life Insurance Company or its authorized representative any information needed to determine policy claim benefits. This may include (but is not limited to) information regarding HIV antibody testing, Acquired Immune Deficiency Syndrome or related complexes, driving records, financial records, police or accident reports, mental illness and use of alcohol or drugs. A photocopy of this form is as valid as the original. This form will be in force for one year from the date shown below. I may revoke it at any time for information not then obtained by writing to Monumental Life Insurance Company. I certify that the foregoing statements and answers on this form are complete and true to the best of my knowledge.

Signature of Member	Spouse's Signature (if Patient)	Date

Instructions for filing claims

1. Send this **fully** completed claim form to:
   National Employee Benefit Companies, Inc. (NEBCO)
   P.O. Box 153085
   Irving, TX 75015-3085
2. Attach all UB92 hospital bills, HCFA1500 physicians bills, physicians superbills (these are standard billing statements used by your providers of service) and any other appropriate medical bills. For HMO or Medicare insureds, please submit verification of confinement from the Hospital if a UB92 hospital bill is not available. All bills must include a diagnosis from your provider of service.
   For **Cancer** claims include a pathology report verifying malignancy with all initial submissions.
3. If you have any questions call us at **800-808-4515.**

Attending Physician's Statement

(to be completed by your physician)

1. Date of First Symptoms	2. Date First Consulted for this Condition	3. Date Condition First Diagnosed
______________________	_________________________	________________________

4. Has patient ever been previously treated for this condition or related conditions?
☐ Yes ☐ No If yes, give date and diagnosis of prior advice and treatment

5. Name and address of physician who referred this patient

6. Name and address of hospital where services rendered

7. Name and address of Nursing Home where services rendered

8. For Services Performed in Hospital	Date Admitted	Date Discharged	9. For Services Performed in Nursing Home	Date Admitted	Date Discharged
	______________	______________		_______________	_______________

10. Inclusive Dates Patient was confined in an Intensive Care Unit of Hospital
____________ to ______________

11. Please provide names and addresses of other physicians currently treating patient

12. Diagnosis of illness or injury requiring services
(Relate Diagnosis to procedure by reference to numbers 1,2,3, etc. In col. D)
1.
2.
3.

13. A	B	C		D	E
Date of each service	Place of Service * see code Below	Describe surgical or medical procedures and other services furnished for each date given Procedure code	(Explain unusual circumstances)	DX No.	Charges

Date	Physician's name (print)	Signature	Degree	Total Charges
Street Address	City	State	Zip Code	

________-_______-_______ Individual Practitioners SS#

____-______________ Employer Tax ID #

* Place of Service Codes

1-(IH) Inpatient hospital	4- (H) Patient's home	7- (NH) Nursing home	O- (OL) other locations
2-(OH) Outpatient hospital	5- psychiatric day care facility	8- (SNF) Skilled nursing home	A- (IL) independent Laboratory
3-(O) Doctors office	6- Psychiatric night care facility	9- Ambulance	B- (ASC) Ambulatory Surgical Center

TO BE COMPLETED BY INSURANCE PLAN ADMINISTRATOR

Policy\division Number ________________________ | Certificate Number

Coverage ☐ Insured only ☐ Insured and Spouse ☐ Insured and all Dependents

Original Date of Coverage ____________	Coverage selection_______________	Optional Riders_______________
Date of Coverage Change ____________	Coverage selection_______________	Optional Riders_______________
Date of Coverage Change ____________	Coverage selection_______________	Optional Riders_______________

Has Insurance Terminated? ☐ No Premium Paid to _______________

☐ Yes Date of Termination _______________

If yes, WHY? ☐ lapse ☐ cancellation ☐ Death Date of Death ______________

Name of Administrator	Signature of Representative\Title	Date

Insured or Authorized Representative: Sign this form and return with the claim form to:

National Employee Benefit Companies, Inc. (NEBCO)
P.O. Box 153085
Irving, TX 75015-3085

Please keep a copy of this form for your records.

AUTHORIZATION FOR USES AND DISCLOSURES OF MEDICAL INFORMATION

To: Monumental Life Insurance Company ("Insurer")

I hereby give Insurer permission to obtain, use and/or disclose the below Insured's personal health information as follows:

- This authorization was prepared at the request of Insurer for the purpose of evaluating contestability and/or eligibility for benefits.
- The information that is the subject of this authorization and which will be used or disclosed as set forth below includes the release of **all medical records** (except psychotherapy notes), including, but not limited to, those containing medical history, diagnoses, symptoms, treatments, prescription drug information alcohol or drug or tobacco use or abuse or information regarding communicable or infectious conditions, such as AIDS.
- The following person(s) or group of persons employed or working for, or on behalf of Insurer may obtain, use or disclose the Insured's personal health information which is described above: Any physicians, medical practitioners, hospitals, clinics, medical or medically related facilities, paramedic facilities, treatment or recovery centers, governmental agencies, insurance support organizations, medical record retrieval services, pharmaceutical services, plan administrators, insurance companies, reinsurers, independent medical consultant or counsel and consumer reporting agencies such as the Medical Information Bureau.
- I understand that if the person or entity that gives or receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Insurer in reliance on this authorization, by sending a written revocation to: National Employee Benefit Companies, Inc.(NEBCO), P.O. Box 153085, Irving, Texas 75015-3085
- I understand that I am not required to sign this authorization form and that Insurer will not condition the provision of payment of benefits on the signing of this authorization, except that Insurer may condition evaluating contestability or insurance coverage eligibility for benefits on provision of this authorization if the authorization sought is for insurance coverage contestability evaluation or insurance coverage eligibility relating to the Insured. This authorization will expire 24 months from the date this authorization is signed.

Insured's Name (Print)	Insured's Date of Birth
Authorized Representative's Name (Print)	Relationship to Insured
Signature of Insured or Authorized Representative	Date