



CLAIMANT'S STATEMENT AND AUTHORIZATION

(See reverse side for Directions for Submitting a Claim)

USE THIS FORM FOR CLAIMS IN: CA, CO, FL, ID, IN, KY, MO, NC, SC, SD, TX, VA and WY

PART A: Complete for all claims. **All Checks and Correspondence Will Be Sent To The Address Below**					
Insured Name:			Claimant (Patient) Name:		
Sex:	Birthdate:	Sex:	Birthdate:		
Street Address:		City:	State:	Zip:	
Home Telephone:	Work Telephone:	Fax Number:	E-mail address:		
Plan Number:			Certificate Number:		

1. Is the Claimant: A full-time Student? Yes No If yes, please provide the name and address of school: _____
2. Is the Claimant: Employed? Yes No If yes, please provide the name and address of employer: _____
3. Do you or any family members have other coverage (medical, indemnity or liability) which might help cover hospital and medical expenses? Yes No If yes, please provide the following:

Name of Company:	Address:
Policyholder:	Policy Number:
Is this group insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PART B: Complete for new claims. If you need additional space, please attach additional sheets.

1. How did the condition begin? State fully all symptoms and describe the condition in detail from the beginning:
2. When did the first symptoms of this condition begin? State the exact date, if possible:
(If due to an accident, please complete accident questionnaire, see Part C- DIRECTIONS)
3. Have you ever had or been treated for the same kind of illness or injury? Yes No If Yes, when?
Name, address and telephone number of attending physician:
4. Name, address and telephone number of family physician (even if not consulted):

5. What ailments, diseases, illnesses, conditions or injuries have you had during the last 12 months? Please provide name and/or description of each condition, dates involved, and the name, address and telephone numbers of attending physicians:

PART C: Complete for all claims.

I verify that all information contained in this form is true, correct and complete to the best of my knowledge. I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to HCC Life Insurance Company. I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed:

Signature of Insured:	
Print Name:	Date:

Signature of Patient:	
Print Name:	Date:

ASSIGNMENT OF BENEFITS AUTHORIZATION: I authorize payment of medical benefits to the doctor or other supplier of services submitting the attached bills.

Signature of Insured:	Date:
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DIRECTIONS FOR SUBMITTING A CLAIM

1. If this is a new claim, complete ALL PARTS of this form.
2. If this is a continuing claim, complete Parts A and C only.
3. Attach all original itemized bills for services and supplies. Please verify that the documents indicate your name, date of service, diagnosis and the charge for each service.
4. Mail to: **HCC Life Insurance Company**
P.O. Box 863
Indianapolis, Indiana 46206
5. If you have any questions, call 1-866-400-7102. If calling from outside the US, call collect to 317-221-8095.

INDIANA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: 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.