SUREGO Administrative Services

Accidental Death & Dismemberment

CLAIM FORM & CLAIMANT'S STATEMENT

INSURED / PATIENT / DECEDENT INFORMATION

Insured Name			Policy No.
Date of Birth	Member ID#	Email Address	
Home Address Number & Street	City	State	Zip Code
Name of Deceased / Patient / Relation			Date of Birth
Address (if different) Number & Street	City	State	Zip Code

CLAIM INFORMATION

This claim is being made under: *Check one*	☐ Accidental Death ☐ Accidental Dismemberment		
Nature of Dismemberment — Loss of:		*Check one*	
	☐ Right Hand ☐ Left Hand ☐ Both Hands	☐ Right Foot ☐ Left Foot ☐ Both Feet	☐ Sight of Right Eye ☐ Sight of Left Eye ☐ Sight of Both Eyes
Date of Injury		Date of death	
Place where accident happened			
Describe how and where accident occurred			
Name of Beneficiary for death benefit			
Address (if different) Number & Street	City	State	Zip Code

IMPORTANT: THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM DATE OF LOSS.

STATEMENT OF ATTENDING PHYSICIAN – FOR DISMEMBERMENT BENEFITS

Patient's Name:	Date of Birth:
1) Nature of injury:	2) Date of injury:

3) Is the claim made for a loss which from illness, disease, bodily infirmity or any bacterial infection occurring from an accidental cut or wound, rather than from the injury sustained? ☐ Yes ☐ No

Nature of Loss

4) If the claim being made due to a loss of member, was the loss due to the injury sustained and not directly or indirectly from any disease or infirmity of mental or bodily nature? ☐ Yes ☐ No

a) Was an amputation performed at or above the wrist or ankle? ☐ Yes ☐ No

☐ Right Hand ☐ Left Hand ☐ Right Foot ☐ Left foot

b) Date performed

Loss of Vision

5) If the claim is being made is for loss of vision, is the loss of sight recoverable by natural, surgical or artificial means? ☐ Yes ☐ No

Loss of Hearing

6) If the claim is being made is for loss of hearing, is the loss of hearing total and permanent in both ears? ☐ Yes ☐ No

a) Is the loss in either ear correctable by any means? ☐ Yes ☐ No

b) If yes, please provide further detail:

Loss of Thumb and Index Finger of Same Hand

7) If the claim is being made is for loss of thumb and finger of same hand, was there a complete Severance* through or above the metacarpophalangeal joints? ☐ Yes ☐ No *(*Severance meaning the complete separation and dismemberment of the part from the body.)*

a) If no, please describe the loss

Physicians Name and Address Number & Street	City	State	Zip Code
Physician's Phone Number:	Fax #:	TIN:	
Signature of Physician:	Date:		

SELECT ONE FORM OF REIMBURSEMENT

☐ Send a check to address, as listed in CLAIMANT INFORMATION section.		
☐ Send a check to other mailing address:	Street Address	City
	State	Zip Code
☐ Send by Electronic Direct Deposit (fill all fields):	Bank Name	Name on Account
	Account #/IBAN	Routing #/ABA # (for Electronic Direct Deposit)

List of Supporting Documents Needed

FOR DEATH BENEFITS

A notarized copy of the death certificate must be submitted.

Any police report

A copy of the autopsy report including toxicology results.

Medical Records.

FOR DISMEMBERMENT BENEFITS

The attending physician must fill out Page 2 and sign.

Medical Records.

Authorization I AUTHORIZE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, rental agency, hotel, motel, or similar entity providing lodging on a rental/lease basis or any other person who may have knowledge regarding this claim, to release any information requested by Surego Administrative Services/or their affiliate partners regarding this claim and the loss reported. I also authorize Nationwide Life Insurance Company and Nationwide Mutual Insurance Company or its representative to release and share claim information including that which may be used in the identification and prevention of potentially fraudulent activity to any insurance organization, fraud information clearinghouses, designated service providers and business associates assisting in the processing of this claim. I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file one. I have read and understand the Fraud Notices.

Patient Authorization for Release of Medical Information In order to process a claim for benefits, I authorize any physician, hospital, or other Medical Provider to release to Surego Administrative Services, or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed two and one-half years from the date signed. I understand I have a right to receive a copy of this authorization.

Reimbursement Authorization and Method I hereby authorize Surego Administrative Services to mail any payments to the address listed on claim form or to deposit any amounts owed me for reimbursement of medical expenses or services rendered by initiating credit entries to my account at the financial institution (hereby BANK) indicated on claim form. Further, I authorize BANK to accept and to credit any credit entries indicated by Company to my account. In the event that Company erroneously deposits funds in my account (by way of example, I am not entitled to the funds or the amount of deposit Is incorrect or such funds are deposited in the wrong account), I authorize Company to debit or credit my account in the amount necessary to correct the initial deposit, but in no case shall any debit exceed the amount of the initial deposit. I further agree that Company is not responsible for any transaction fees charged and will release Surego Administrative Services of any liability in the event of lost or stolen payments. I authorize Surego Administrative Services to contact me using the email address I provided in this form to discuss and/or inform me of payment confirmation.

Your Rights Under Federal Law You have the right to authorize that the confidential information held by Surego Administrative Services and/or Trawick International be released to and/or received by persons or organizations you identify as indicated below with your signature. You are entitled, upon request, to receive a copy of this signed form. I hereby authorize the request and release of my confidential information held to my personal representative. By appointing the person named below as my personal representative, I understand that I am authorizing to give this person access to my confidential information and medical records, the right to talk to about my medical care and the right to make decisions that will bind me. I agree that a photocopy, emailed copy or facsimile (FAX) copy of the authorization shall be accepted and as valid as the original. This "PERSONAL REPRESENTATIVE DESIGNATION" is subject to revocation at any time except to the extent that action has been taken in reliance hereon and, if not earlier revoked in writing, it shall remain valid for two (2) years from date of signature.

Personal Representative Designation When elected, I hereby authorize the request and release of my confidential information held to my personal representative. By appointing the person named above as my personal representative, I understand that I am authorizing to give this person access to my confidential information and medical records, the right to talk to about my medical care and the right to make decisions that will bind me. I agree that a photocopy, emailed copy or facsimile (FAX) copy of the authorization shall be accepted and as valid as the original. This authorization is subject to revocation at any time except to the extent that action has been taken in reliance hereon and, if not earlier revoked in writing, it shall remain valid for two (2) years from date of signature.

New York Fraud Warning 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.

Signature	Date

Underwritten by Nationwide Mutual Insurance Company, Columbus, Ohio. In WA coverage is underwritten by Nationwide Life Insurance Company, Columbus, Ohio and Nationwide Mutual Insurance Company, Columbus, Ohio

State Fraud Notices *Updated on 12/6/2022*

(Alabama) Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

(Alaska) 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.

(Arizona) Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

(Arkansas) 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.

(California – Claim & Application Forms) For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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 within the department of regulatory agencies.

(Delaware) Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

(District of Columbia) 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.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(Idaho) Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

(Indiana) Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

(Kentucky) Application Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

(Kentucky) Claim 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.

(**Louisiana**) 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.

(Maine) 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.

(Maryland) Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Minnesota) A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

(New Hampshire) 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.

(New Jersey) Claim Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

(New Jersey) Application Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

(New Mexico) 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 civil fines and criminal 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 $5,000 and the stated value of the claim for each such violation.

(Ohio) 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.

(Oklahoma) 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.

(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.

(Rhode Island) 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.

(Tennessee) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

(Texas) 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.

(Virginia) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

(Washington) It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

(West Virginia) 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.

(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files anapplication 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 tocriminal and/or civil penalties.

Economic or Trade Sanctions: Any payments under this policy will only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to, sanctions, laws, and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"). Therefore, any expenses incurred, or claims made involving travel that is in violation of such sanctions, laws and regulations will not be covered under this policy. For more information, You may consult the OFAC internet website at https://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx

Electronic Communication: 1. Consent to receive insurance related documents and communications, including but not limited to, your policy documents, disclosures, notices, explanation of benefits (EOB), claims documentation, as well as termination and cancellation or non-renewal notices, electronically to the email address you provide to us through the online application process instead of receiving these records in a paper format from us. 2. Agree and acknowledge that your consent is provided and/or obtained in connection with a transaction affecting interstate commerce subject to the Electronic Signatures in Global and National Commerce Act and the Uniform Electronic Transactions Act, or a similar electronic transactions law, as adopted by state law. 3. Agree that the document(s) delivered to you electronically shall have the same meaning and effect as if you were provided a paper document, whether or not you choose to view the document(s), unless you previously withdrew your consent to receive documents via electronic means as provided below. Electronic document(s) are considered received by you at the time you complete your purchase, unless we receive notice that the email notification was not delivered to you at the email address you provided.

Fraud Warning: If the Covered Person or any person acting on his/her behalf shall make any claim or statement knowing the same to be false or fraudulent as regards to amount or otherwise, then this Insurance shall become void and all claims here under shall be forfeited without refund of premium.

MAILING INSTRUCTIONS
Attention: Surego Administrative Services On Behalf of Nationwide Life Insurance Company and Nationwide Mutual Insurance Company
PO Box 2069
Fairhope AL, 36533
Email: claims@mysurego.com

Toll Free:(866) 686-0930 Direct Dial:(251) 244-3942

File Online: https : / / www . mysurego . com

Attending Physician Statement

Section 1: TO BE COMPLETED BY CLAIMANT/INSURED

Certificate Number or Member ID	Protection Plan Purhcase Date
Name of person having sickness or injury	Date of Birth
Date Sickness or Injury began	Date ended

Nature of Sickness or Injury (If injury, describe accident, including date and place):

Period of hospitalization dates (if applicable) From: To:

Authorization For Release of Medical Information – To be Completed by Patient

I hereby authorize Nationwide Life Insurance Company and Nationwide Mutual Insurance Company, Columbus, Ohio, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data necessary to determine eligibility of benefits. I also authorize Nationwide Life Insurance Company and Nationwide Mutual Insurance Company, Columbus, Ohio, or its representative to release and share claim information including that which may be used in the identification and prevention of potentially fraudulent activity to any insurance support organization, fraud information clearinghouses, designated service providers and business associates assisting in the processing of this claim. A photo-static copy of facsimile of this authorization shall be deemed as effective and valid as the original. This authorization is valid for twelve (12) months from date of signature.

Signature	Date

(Signature of Person Suffering Illness or Injury or legally authorized representative)

Section 2: TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Name of patient	Date of Birth

Address

Diagnosis (ICD)

Symptoms

Date symptoms first appeared, or accident occurred

Date of first treatment	Date of last treatment

List of all exam/treatment dates after initial consult

Was the patient treated by someone else? Yes No
If so, by whom? When?
Has the patient ever had this condition before? Yes No
If yes, dates of prior treatment
Is this condition an exacerbation or a complication of an existing condition? Yes No
If yes, when did the condition worsen?
Has the patient received medication or other treatment for this condition, or for a related condition, by you or any other Physician during the 90 days immediately prior to the date the claimant purchased this protection plan (see page 1 for date of purchase)? If so, please provide exact dates and details:
If the patient is the traveler, did you prohibit patient's traveling? Yes No
On what date was the patient/traveler disabled to travel?
Explain the restrictions that prevent the patient's travel on their date of departure
How long will the restrictions on travel be in effect for the patient?
Any false or misleading statements made in support of and resulting in the payment of a claim shall be subject to legal action for collection of damages to the insurance company against the person or persons making such false and / or misleading statement.

Physician's Signature		Date Completed
Physician Name		Taxpayer ID Number
Phone Number	Fax Number	Email