HOSPITAL INDEMNITY CLAIM FORM

INSTRUCTIONS

— ***COMPLETE*** *the Member Information Section for all claims.*
— *Complete the Patient Information Section when submitting a claim for a covered dependent.*
— *Always sign and date the Member Certification.*
— *Always sign and date the Authorization for Release of Information. If the claim is for a dependent, the patient or patient's parent/guardian must sign and date.*
— *Attach all itemized bills.*

MAIL COMPLETED FORM AND ANY ITEMIZED BILLS TO: AVMA LIFE Trust
Program Administrator
1200 E Glen Ave
Peoria Heights, IL 61616
1-(800)-621-6360

MEMBER INFORMATION

▶ 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

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: _____

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**

AVMA LIFE®
Veterinarian Inspired Coverage