# Insurance Claim Filing Instructions

**PROOF OF ACCIDENTAL DISMEMBERMENT / PARALYSIS / LOSS OF VISION SHALL CONSIST OF THE FOLLOWING:**

1. A completed and signed claim form
2. Proof of Coverage
3. Official Accident, Incident, Toxicology or Medical Examiners Reports
4. Attending Physician's Statement
5. Authorization to obtain medical records
6. Copy of the Ambulance report or medical report, if available

**A PROPERLY COMPLETED CLAIM FORM WILL ASSIST US IN THE PROMPT PROCESSING OF YOUR CLAIM**

## Return Claim Form to:

**Administrative Concepts, Inc.**
**ATTN: Claims Department**
**P.O. Box 4000**
**Collegeville, PA 19426-9000**
**1-888-293-9229**

**Note: If you need additional space in order to complete the Claim Form, please attach a separate sheet of paper with your responses.**

**When the manner of dismemberment / paralysis / loss of vision was due to an accident, self-inflicted wound or assault**, we require a copy of the police report, emergency medical services report, and accident report if available or the name, address and telephone number of the office where this information can be obtained.

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# NOTICE TO POLICYHOLDERS

**FRAUD NOTICE**

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| **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. |
| **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.** |
| **District of Columbia** | **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. |
| **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. |
| **Kansas** | A "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto. |
| **Kentucky** | 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. |
| **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 denial of insurance benefits. |
| **Maryland** | Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. |
| **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** | 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. |

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| **New York** | **General: All applications for commercial insurance, other than automobile insurance:** 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.<br><br>**All applications for automobile insurance and all claim forms:** Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation.<br><br>**Fire:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.<br><br>The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy. |
| **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** | **All Commercial Insurance, Except As Provided for Automobile Insurance:** 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.<br><br>**Automobile Insurance:** Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to $15,000. |
| **Puerto Rico** | **Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.** |

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| **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** | **All Commercial Insurance, Except As Provided for Workers' Compensation** 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.<br><br>**Workers' Compensation:** It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits. |
| **Utah** | **Workers' Compensation:** Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services 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 willfully presents false information in an application for insurance may be guilty of insurance fraud and subject to fines and confinement in prison. (In Oregon, the aforementioned actions may constitute a fraudulent insurance act which may be a crime and may subject the person to penalties). |

# Catlin Insurance Company, Inc.

## A. INSURED INFORMATION

Insured's Name: _____ Social Security #: _____ Date of Birth: _____

Insured's Address: _____

Marital Status: _____ Occupation: _____

Phone Number (home): _____ Phone Number (work): _____ Phone Number (cell): _____

Policyholder Name: _____

Policyholder Address: _____

Policy Number (required): _____

## B. CLAIMANT INFORMATION (if not the insured)

Claimant's Name: _____ Relationship to Insured: _____

Claimant's Address: _____

Date of Birth: _____ Social Security #: _____

Occupation: _____

## C. PROOF OF COVERAGE

Provide documentation that proves coverage was in force at the time of the covered accident, such as:

- **The Insurance Policy**
- **Summary Plan Document**
- **Certificate of Insurance**
- **Other similar plan documentation**

# Catlin Insurance Company, Inc.

## Accidental Dismemberment / Paralysis / Vision Claim

### D. DESCRIPTION OF ACCIDENT

Date of Accident: _____ Time of Accident: _____ Location of Accident: _____

Date of Covered Loss: _____

Please describe in detail the circumstances of accident and the cause of the covered loss (attach separate sheet if needed):

_____

_____

_____

Did the Accident occur during the course of the Claimant's employment?: _____

Name of Attending Physician: _____

### E. REQUIRED DOCUMENTATION

The following documents must accompany this claim form (if applicable):

- **Police Report**
- **Death Certificate**
- **Coroner's Report**
- **Inquest Verdict**

### F. OTHER INSURANCE

List all other Insurance Policies paying benefits for this covered loss:

| | | | | | |
|---|---|---|---|---|---|
| Insurance Company: | _____ | Policy Number: | _____ | Principal Sum: | _____ |
| Insurance Company: | _____ | Policy Number: | _____ | Principal Sum: | _____ |
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| Insurance Company: | _____ | Policy Number: | _____ | Principal Sum: | _____ |

# Catlin Insurance Company, Inc.

## Accidental Dismemberment / Paralysis / Vision Claim **(continued)**

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by Catlin Insurance Company, Inc. or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I hereby authorize Catlin Insurance Company, Inc. or its authorized representative to release the information described above to any expert, investigator, physician, medical practitioner, hospital, medical or medical related facility, insurance company, reinsurer, plan administrator, plan sponsor or employer for the purpose of investigating and /or adjudicating this claim. A copy of this authorization shall be considered as effective and valid as the original.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

**SIGNED (Authorized Person)** _____ **Date** _____

**Print Name Here** _____


# ATTENDING PHYSICIAN'S STATEMENT – Dismemberment/Paralysis/Vision

1. Name of Patient/Claimant: _____

1 a. of (address): _____

2. How long has the claimant been your patient: _____

3. Date of Loss of Limb / Paralysis / Vision (mm/dd/yyyy): _____

4. What was the primary cause of Loss of Limb / Paralysis / Vision? _____

5. Was the Loss of Limb / Paralysis / Vision due to natural causes or due to an accident? _____

6. Date of Accident (mm/dd/yyyy): _____ Hour of Accident: _____

7. Describe the claimant's condition when you first attended to him/her:

_____

_____

_____

8. How did the accident occur?

_____

_____

_____

9. What was the precise nature and extent of the injuries?

_____

_____

_____

10. Dismemberment: Which Limbs have been lost?

_____

10 a. State the exact point at which each Limb was separated from the body:

_____

11. Paralysis: Is the Paralysis permanent and irreversible?

_____

11 a. What part(s) of the Claimant's body is considered to be permanently paralyzed?

_____

12. Loss of Vision: Has Vision been reduced to 20/200 or less with correction, in each eye?

_____

12 a. is the Loss of Vision irreversible?

_____

13. Was there a secondary or contributory cause of Loss of Limb / Paralysis / Vision? If so, what?

_____

14. Did any disease cause, other than the injury referred to, operate as a complication, or contribute to produce Loss of Limb / Paralysis / Vision? If so, what?

15. Was an alcohol and/or drug screen performed? If so, what was the result?

16. Was the claimant confined in a hospital? If so, please offer the dates of confinement.

Physician's Name (Print) Signature Date

Physician's Address: *Street* *City* *State* *Zip*

# AUTHORIZATION
# FOR RELEASE OF INFORMATION

**CLAIMANT (name)** _____

**POLICY NUMBER:** _____ **BIRTHDATE** _____

Solely to assist Catlin Insurance Company, Inc. in administering an insurance claim, I hereby authorize any physician, doctor, dentist, clinic, hospital, pharmacy, or other medical professional, or any insurance company, employer, coroner, medical examiner, law enforcement agency, governmental agency or other person or organization possessing medical, employment, financial, insurance and/or police record information on the individual named above, to permit Catlin Insurance Company, Inc., its affiliates or its representatives, to view, copy, be furnished copies or be given details of my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This protected health information and other information includes any medical information, employment or financial information, insurance policy and claim history, and/or police record information including but not limited to, mental and physical condition, evaluation, diagnosis, treatment, prognosis, autopsy protocol and findings, and/or toxicology results; specifically to include drug, alcohol, mental illness, psychiatric treatment or diagnosis, testing, and/or treatment of HIV (AIDS virus) and/or other sexually transmitted diseases.

**By my signature below, I terminate any agreements I have made with my providers to restrict my medical records and any associated HIPAA protected health information and I instruct my providers to release and disclose my entire medical record without restriction.**

This protected health information and other information is to be disclosed under this Authorization so that Catlin Insurance Company, Inc. may: 1) administer claims and determine or fulfil responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with Catlin Insurance Company, Inc., its subsidiaries and affiliates.

This Authorization is valid from the date signed for the duration of the claim not to exceed 24 months from the date of signature. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Catlin Insurance Company, Inc.. I understand that a revocation is not effective if any of my providers has relied on this Authorization or to the extent that Catlin Insurance Company, Inc. has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I also understand that if I refuse to sign this Authorization, Catlin Insurance Company, Inc. may not be able to process claims or properly administer coverage and may result in a denial of coverage. I understand the company will provide me with an additional copy of this Authorization.

Any copy of this Authorization shall have the same authority as the original.

**Authorization given by (sign name here) :** _____

**print name here:** _____

**Date signed:** _____

**Relationship to Claimant:** _____