



Attention: Claims Department  
P.O. Box 1650  
Little Rock, Arkansas 72203-1650  
Telephone (800) 370-5856  
Fax (501) 235-8416  
E-mail: claims@usablelife.com

## Statement of Claim Hospital Income Policy Benefits Intensive/Coronary Care Benefits

For H.O. Use Only
Eff _____
PTD _____
Plan Code _____
Issue Age _____

- Instructions:**
1. Please make sure all questions on Insured's statement are completed in full.
  2. Authorization must be signed and currently dated.
  3. Physician Statement on page 2/reverse side must be completed.

### INSURED'S STATEMENT

Insured Name (Last, First)	Policy Number (Very Important)		
Home Address (City, State, Zip)	Telephone Numbers		
	Home	Work	
Patient Name (Last, First)	Patient's SSN	Date of Birth	Relation to Insured

Describe symptoms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of first treatment: \_\_\_\_\_

Name and address of first doctor seen: \_\_\_\_\_  
\_\_\_\_\_

Names and addresses of all doctors and hospitals consulted for **this** condition (Use separate sheet if necessary):

Physician/Hospital	Address, City, State and ZIP
_____	_____
_____	_____
_____	_____

Have you ever had this or similar condition before?     Yes     No

If yes, give particulars:                      Date: \_\_\_\_\_

Describe: \_\_\_\_\_

Names and addresses of all doctors and hospitals consulted for **ANY** condition in the past five years (Use separate sheet if necessary):

Physician/Hospital	Address, City, State and Zip	Condition
_____	_____	_____
_____	_____	_____

#### Authorization to Obtain Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to US Able Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original. I acknowledge that I have a right to a copy of this authorization upon request.

**FRAUD WARNING:** Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

**Date:** \_\_\_\_\_                      **Signature of Patient:** \_\_\_\_\_  
(Parent/Guardian if Minor)

Please have your Attending Physician complete Page 2/reverse side  
and attach itemized copies of your bills.

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## ATTENDING PHYSICIAN'S STATEMENT

**Please answer all questions and attach itemized bill for all covered services to date.**

Diagnosis and concurrent conditions (Include ICD Code)

Date symptoms first appeared _____	Date patient first consulted you _____		
If hospitalized, date _____ <div style="text-align: center; margin-top: 5px;"> <input type="checkbox"/> Inpatient                      <input type="checkbox"/> Outpatient                 </div> Hospital Name _____ City, State _____			
Have you treated this patient for other conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give dates and describe _____ _____ _____			
Has patient ever had same or similar condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, Date _____			
Was patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name and address of referring doctor _____ _____			
Physician's Signature _____	Date _____		
Physician's Name (Please Print or Type) _____	Degree _____		
Address _____	Telephone _____		
City _____	State _____	Zip _____	Fax _____

## **FRAUD NOTICE**

For your protection, the laws of some states may require us to furnish you with the following notice:

Except as otherwise noted below, it is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable 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.

### **California**

Any person who knowingly presents 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 within the department of regulatory agencies.

### **Florida**

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim 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.

### **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.

Retain for your records.