



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

## HOSPITAL CONFINEMENT INDEMNITY CLAIM FORM & INSTRUCTION PACKET

### Dear Policyholder:

Thank you for choosing USABLE Life to provide your Hospital Confinement Indemnity coverage. We have included these instructions and the necessary forms to assist you in the event you need to file a claim. Please remember that claims must be received within 90 days of the loss or date of confinement. You and your attending physician must complete the claim form. An Authorization for Release of Medical Records must be completed and returned along with the completed claim form. If faxing a claim, the original must also be mailed.

**IMPORTANT NOTE: Losses resulting from motor vehicle accidents or homicide require a copy of the investigating officer's report. Incomplete claims cannot be processed and will be returned to you.**

### CLAIMS FOR MEDICAL EXPENSES

1. Complete the Insured Employee/Patient's Statement on page 2.
2. Obtain the Attending Physician's Statement – Medical Expenses found in this packet.
3. Obtain ITEMIZED bills from all medical providers.
4. Complete the Authorization for Release of Medical Records.
5. Fax or Mail the completed forms and ITEMIZED bills to USABLE Life.

### WELLNESS BENEFIT (If applicable to your policy.)

1. Please fax or mail us an ITEMIZED bill for the covered test or service. Payment will be mailed to the address on the bill. Please make sure this address is correct. (Do not rely on your physician or hospital to file your claim.)
2. You do NOT need a claim form or an Authorization for Release of Medical Records to collect reimbursement for these benefits BUT the following information must be submitted:
  - Insured's name and Social Security number.
  - Policy Number (very important)
  - Patient's Name, Date of Birth and Social Security Number
  - Date of Service
  - You may write the above on the itemized bill for submission

### For Questions or Assistance or to Submit Claim Forms and Itemized Bills:

By Mail:  
USABLE Life  
Attention: Claims Department  
PO Box 1650, Little Rock AR 72203-1650  
Telephone: (800) 370-5856  
8:00 a.m. – 4:30 p.m. Central Time

By Fax:  
USABLE Life  
Attention: Claims Department  
(501) 235-8416

**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.



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## Statement of Claim Hospital Confinement Indemnity

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

- How To File Your Claim:**
1. Please make sure all questions in the Insured Employee/Patient's Statement section are completed in full.
  2. Authorization must be signed and currently dated.
  3. Physician Statement on page 3 must be completed.

**Type of Claim:**     Inpatient Hospital     Accident/Injury

### Insured Employee/Patient's Statement

Employee's Name (Last, First, MI)		Employee's Birthdate	Employee's Social Security No.
Employee's Address (Street, City, State, Zip)		Employee's Daytime Telephone No.	
Employer Name	Group Policy #	Current Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> On Leave <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed	
Employer Address (Street, City, State, Zip)		If on leave, retired or not employed: Date Last Worked    Mo    Day    Year	
Patient's Name (Last, First MI)		Patient's Birthdate	Patient's Social Security No.
Patient is: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:		Specify Relationship	
If Patient is your child, is he living in your household? <input type="checkbox"/> Yes <input type="checkbox"/> No		(If no, specify with whom the child resides.)	
If patient is your child, is he a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		School Name	
Nature of Illness or Injury		Date of 1st Treatment	
Accident Date	Time (include a.m. or p.m.)	Place	
How did the accident happen?			
Has the patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, indicate date and describe	
Has patient had other medical attention in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Describe conditions, name doctors consulted, hospitals where treated, their addresses, and give dates seen. (Attach separate sheet if needed.) _____ _____			

#### 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."

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Date: \_\_\_\_\_ Signature of Patient \_\_\_\_\_  
Parent/Guardian (if patient is a minor)

**Please have your Attending Physician complete Page 3  
and attach itemized copies of your bills.**

**ATTENDING PHYSICIAN'S STATEMENT – MEDICAL EXPENSES****Please Answer All Applicable Questions**

Name of Patient		Date of Birth
Nature of Injury or illness (Include ICD Codes)		When Did it Occur
Date Patient First Consulted You	Date symptoms first appeared	Has Patient Ever Had Same of Similar Condition? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, When: _____
If hospitalized, date _____ <input type="checkbox"/> In Patient <input type="checkbox"/> Outpatient		
Hospital Name: _____		
City, State _____		
If loss of limb, was it through or above wrist or ankle Joint? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If loss of sight, is it permanent or irrecoverable? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, on what date did it become so? Date: _____ If No, what percentage of sight remains? _____
Was the loss of sight or dismemberment solely due to accidental bodily injury without other causes? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If No, Please explain:		
Were any surgical procedures involved? <input type="checkbox"/> Yes <input type="checkbox"/> No Please Describe:		Date Performed
If loss due to burn, specify degree and size: <input type="checkbox"/> First Degree <input type="checkbox"/> Second Degree _____ Percentage of Body Surface Burned <input type="checkbox"/> Third Degree _____ Square Inches of Body Surface Burned		
If loss due to dislocation, complete separation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Open Reduction <input type="checkbox"/> Closed Reduction		
If loss due to fracture: <input type="checkbox"/> Simple <input type="checkbox"/> Compound <input type="checkbox"/> Open Reduction <input type="checkbox"/> Closed Reduction		
If loss due to Laceration: Total Length: <input type="checkbox"/> Less than 5.08 cm <input type="checkbox"/> 5.08 – 15.24 cm <input type="checkbox"/> Greater than 15.24 cm Type of Repair: <input type="checkbox"/> Stitches <input type="checkbox"/> Glue <input type="checkbox"/> Staples <input type="checkbox"/> Other		
<b>I certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.</b>		
Physician's Signature		Date
Physician's Name		Degree
Address	Telephone	Fax
City	State	Zip

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