Madison National Life Insurance Company
A Member of The IHC Group

Mail Claim Form to:
NABCO
Claims Department
P.O. Box 3056
Southeastern, PA 19398-3056
Phone: 800-346-7813 Fax: 610-995-0181

NORTH AMERICAN BENEFITS COMPANY

IMPORTANT: Please read this before submitting a claim.

- ❒ Read, complete, sign and date the Patient Authorization Form and the Fraud Warnings page.
- ❒ Complete all relevant sections, then sign and date the Limited Medical Benefit Claim Form.
- ❒ Have the Attending Physician's Statement completed, signed, dated and submitted by your physician.
- ❒ For Disability claims, have the Employer's or Administrator's Statement completed, signed, dated and submitted by the appropriate person.
- ❒ Make sure all forms are signed and dated - incomplete forms will result in a delay in processing your claim.
- ❒ Include UB type bills or HCFA 1500s with your claim. If these are not available; the bill must include CPT codes, ICD10 codes and the provider's Tax Identification Number. Claims cannot be processed without these documents.
- ❒ Once completed, all required documents should be submitted to the address indicated below:

North American Benefits Company (NABCO)
Claims Department
P.O. Box 3056
Southeastern, PA 19398-3056
(800) 346-7813
Fax: (610) 995-0181

-- Continued --

For Accident Expense Claims:

- ❒ Your Accident Expense Benefit plan requires that treatment must be sought within a specific time frame. Please refer to the Schedule of Benefits in your Certificate of Insurance for the "Initial Treatment Period".
- ❒ Proof of loss (completed claim form and itemized bills) should be submitted within 90 days of the accident. Additional bills related to the accident should be submitted within 90 days of treatment.
- ❒ You are required to provide medical records documenting all treatment received from all treatment providers consulted within the timeframe beginning three months prior to your reported accident through present date. Lack of receipt of all medical records as noted above will result in a delay in the review of your claim.
- ❒ Please attach itemized bills to the claim form. Please provide a hospital bill; a balance due bill from the hospital is not sufficient. An itemized bill is a statement that indicates: 1) The date(s) of treatment, 2) The type(s) of service, 3) The diagnosis, 4) The medical provider's name and address, and 5) The individual charge for each expense.
- ❒ If you have other (primary) insurance coverage, please send us a copy of their payment or denial (Explanation of Benefits) statement.
- ❒ A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, group name, and date of accident.

For Critical Care Claims:

- ❒ You are required to provide medical records documenting all treatment received from all treatment providers consulted within the timeframe beginning three months prior to the date of diagnosis of the critical illness through present date. Lack of receipt of all medical records as noted above will result in a delay in the review of your application.

For Term Life Claims:

- ❒ In order to review this claim we will require: 1) a certified death certificate; and 2) a copy of the most recent beneficiary designation form; and 3) a copy of the obituary if available.
- ❒ If any of the following situations apply to this claim, please provide the information documented below:
  - ❒ If the death was the result of an accident, we must receive a copy of the official accident report from the responding legal authorities.
  - ❒ If there is more than one beneficiary, each beneficiary must complete the beneficiary information on this form.
  - ❒ If the policy is payable to the estate, executors or administrators of the insured, the statement should be completed by the executor or administrator. Documents confirming appointment as executors or administrators must be furnished.
  - ❒ If the policy is payable to a minor or a mentally incompetent individual, the statement should be executed by the court appointed financial legal guardian and a certificate of appointment and qualifications must be furnished.
  - ❒ If a beneficiary is deceased, a certified death certificate for the deceased beneficiary(ies) must also be furnished.

For Accidental Death and Dismemberment (AD&D) Claims:

- ❒ In addition to this form, we also request that you provide our office with the following information:
  - ❒ A complete copy of the official and final accident report from the legal authorities that responded to the scene of the accident.
  - ❒ Medical records documenting all medical treatment from the date of the accident through the present date from all health care facilities at which you received treatment.

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NORTH AMERICAN BENEFITS COMPANY

Patient Authorization Form

You are not required to sign the authorization but, if you do not, Madison National Life Insurance Company may not be able to evaluate or administer your claim(s). Please complete this form in detail to assist us in providing a timely review of your claim for benefits. Please note that we are requesting that you document each of your treating providers, including any physicians, therapists, counselors, specialists, social workers, or any other representative that is providing treatment for your claimed condition(s). Facility name must be included in order to assure that this authorization from will be accepted.

Name (print)	Date of Birth	Telephone number

I authorize the use and/or release of my protected medical and/or mental health information to Madison National Life Insurance Company for the purpose of determining insurance eligibility. I authorize the release of information from:

Provider / Facility Name	Specialty
Address	Phone Number
Provider / Facility Name	Specialty
Address	Phone Number
Provider / Facility Name	Specialty
Address	Phone Number
Provider / Facility Name	Specialty
Address	Phone Number
Provider / Facility Name	Specialty
Address	Phone Number

This form serves as an authorization for Madison National Life Insurance Company to obtain information documenting medical treatment, including patient notes, treatment records, lab reports, physical therapy, diagnosis and prognosis from _____ through two years from the date of this form. This form is also intended to be used to obtain psychological testing and psychological / psychiatric treatment including patient notes and treatment records from _____ through two years from the date of this form.

Also this form provides Madison National Life Insurance Company and any benefit plan administrators, the authorization to obtain information from any pharmacy, other insurance or annuity company, any consumer reporting agency, financial institution or tax preparer, any governmental agency (example Social Security Administration or Public Retirement System), all former and/or current employers, educational facility/entity, vocational or rehabilitation organization, employer sponsored disability/retirement carrier, worker's compensation carrier, and or any other entity or institution that may have information needed by Madison National Life Insurance Company for the review of my claim for benefits.

I understand this information will be used for the sole purpose of evaluating and administering my claim for benefits. I understand that I may revoke this authorization at any time by requesting the revocation in writing and submitting it to Madison National Life Insurance Company and to the providers listed above. I understand if I revoke this authorization, Madison National Life Insurance Company may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). This authorization will remain valid for two full years from the date of my signature.

I understand that in the course of conducting its business, Madison National Life Insurance Company may release/redisclose this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for Madison National Life Insurance Company in connection with my claim(s). I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws. I am aware my medical information may be redisclosed when necessary as part of the review process performed by Madison National Life Insurance Company at any point during the review of my claim or during any appeals that may take place as explained above.

I understand that I have the right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is valid as the original. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my authorization, however I understand if I do not sign this authorization or if I alter its content in any way, Madison National Life Insurance Company may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to each of my health care providers. I understand that, by signing this form, I am confirming my authorization that my health care provider may disclose to Madison National Life Insurance Company the protected health information described in this form.

Signature _____ **Date** _____

Fraud Warnings

WARNING: 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 may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

ARIZONA WARNING: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA WARNING: For your protection California law requires the following to appear on this form: 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.

COLORADO WARNING: WARNING: 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 damage. 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: 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 WARNING: WARNING: 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.

GEORGIA WARNING: WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

KANSAS WARNING: 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 may be guilty of fraud, as determined by a court of law, and subject to fines, confinement in prison and/or denial of insurance benefits.

KENTUCKY WARNING: WARNING: 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 WARNING: 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 may be guilty of a crime and subject to fines, and confinement in prison.

MAINE WARNING: 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 WARNING: WARNING: 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 WARNING: WARNING: 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 WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK 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 $5,000 and the stated value of the claim for each such violation.

OREGON WARNING: WARNING: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA WARNING: 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 subjects such person to criminal and civil penalties.

TENNESSEE WARNING: WARNING: It is a crime to knowingly supply 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 WARNING: WARNING: 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.

Signature _____ **Date** _____

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NORTH AMERICAN BENEFITS COMPANY

LIMITED MEDICAL BENEFIT CLAIM FORM

To avoid any delays in your Claim, you MUST fill out this page in it's entirety, complete all other relevant sections of this form, and sign and date where indicated.

EMPLOYEE INFORMATION

Employer			Policy or Plan Number	
Employee / Insured Name (Last, First, MI)	Date of Birth	Gender ❒ Male ❒ Female		Social Security Number
Address	City		State	Zip Code
E-mail Address	Phone Number			
Treatment Date of Service	Diagnosis for Treatment	Present Work Status ❒ Active ❒ Retired ❒ COBRA ❒ Terminated ❒ Leave of Absence		Date last actively at work

This claim is for (Check one box to identify the patient for the claim. If the patient is your spouse or child, complete the information below.)

❒ Myself ❒ My Dependent	Name	Date of Birth	Gender ❒ Male ❒ Female	Social Security No.	Relationship

Are you covered by any other plan (including Worker's Compensation) for expenses related to this claim? ❒ Yes ❒ No (If Yes, provide the following)

Insured / Member / Owner Name	Effective date	Termination date (if applicable)
Insurance Company / Carrier	Policy Number	
Address	Telephone Number	

Was a claim filed with your Workers' Compensation carrier? ❒ Yes ❒ No If No, please explain why

Is this claim for an accident? ❒ Yes ❒ No If Yes, please complete:	Date of accident	Was accident job related? ❒ Yes ❒ No	Place of accident ❒ Home ❒ Work ❒ Other _____

ASSIGNMENT

❒ Accepts Assignment - payment will be sent to the provider (Complete below) ❒ Does not accept assignment - payment will be sent to the employee

I hereby authorize Madison National Life Insurance Company, Inc., to pay bills directly to the Hospital or Other Medical Provider as indicated below. I understand that I am financially responsible to the Hospital or Other Medical Provider for charges not covered by the policy.

Signature of Insured Date

Hospital or Other Medical Provider Name	Provider's Address	Telephone number
Hospital or Other Medical Provider Name	Provider's Address	Telephone number

The information I have provided on this form is accurate to the best of my knowledge. I have received, read and signed the Fraud Warnings provided with this form.

Employee / Insured Signature **Date**

-- Continued --

Employee Name _____ **Date of Birth** _____

FOR CRITICAL CARE CLAIMS

Please indicate the illness which you believe will qualify you to receive Critical Care benefits

Have you ever had the same or similar condition in the past? ❒ No ❒ Yes If Yes, please complete the following:

Name and address of the treating physician	Approximate timeframe of previous treatment

Please specify each of the physicians that have treated you for your reported Critical Care:

1) Physician / Facility Name	Specialty
Address	Phone Number
Medical record department fax number	Date Last treated
2) Physician / Facility Name	Specialty
Address	Phone Number
Medical record department fax number	Date Last treated

Medications prescribed (dosage, frequency and date of prescriptions (please feel free to use a separate sheet of paper)

If you have been treated at a hospital or similar institution, please provide the following information:

Name and Address of Hospital	Date of Admission	Date of Discharge

FOR DISABILITY CLAIMS

Date Accident or Sickness began	Date last worked	Date first treated

Nature of Sickness or Injury	If Injured, how and where did Accident happen?
Did Accident happen at work? ❒ Yes ❒ No	Did you file for Workers' Compensation? ❒ Yes ❒ No
Name and Address of physician first consulted for this condition	Name and Address of your family physician

Name and Address of Hospital, if confined	Dates of Confinement: Admit	Discharge

Are you entitled to Benefits from any of the following for this disability?

❒ Workers' Compensation $ _____ ❒ Salary Continuance $ _____ ❒ Local, State or Society Disability Income Plan $ _____

❒ Any Government Agency $ _____ ❒ Social Security $ _____ ❒ No Fault $ _____ ❒ None

For any of the above selected, please provide the following for the insurance company or organization providing such benefits or services:

Policy No.	Name and Address
Policy No.	Name and Address

To all physicians and other medical professionals, hospitals and other medical-care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators: You are authorized to provide Madison National Life Insurance Company, Inc. (Madison National Life) and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on Madison National Life's behalf, with information concerning medical care, advice, treatment or supplies provided the Patient, including information relating to mental illness and drug abuse or alcoholism, and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administrating claims for benefits. I understand that this authorization is valid for the duration of my claim for benefits under Madison National Life's policy. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

Signature of Insured _____ Date _____

-- Continued --

Employee Name _____ **Date of Birth** _____

FOR ACCIDENT EXPENSE CLAIMS

Date and time of accident	Where did the accident occur (Include specific address)
Please describe the Injury sustained as a result of the accident	
Please describe, in detail, the specific circumstances surrounding the accident	

Was this a work related accident / injury?	Are you self employed?	Have you ever had this condition before? (If Yes, please indicate month, date, and year)
❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No

FOR TERM LIFE INSURANCE CLAIMS

Name of deceased	Social Security Number	Date of Birth
Date of Death	Cause of death	

BENEFICIARY 1		BENEFICIARY 2	
Name	Relationship	Name	Relationship
Date of Birth	Social Security Number	Date of Birth	Social Security Number
Complete address		Complete address	
Signature	Date	Signature	Date

BENEFICIARY 3		BENEFICIARY 4	
Name	Relationship	Name	Relationship
Date of Birth	Social Security Number	Date of Birth	Social Security Number
Complete address		Complete address	
Signature	Date	Signature	Date

Authorization

I agree that the written statements of all physicians who attended or treated the deceased and all other papers called for by the Company shall constitute and they are hereby made a part of these proofs of death and further agree that all provisions of law forbidding any physician or other person who attended deceased from disclosing any knowledge or information acquired by him are hereby waived.

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related health care facility or health care provider, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available concerning the diagnosis, treatment or prognosis of any physical or mental condition of the deceased, to give to Madison National Life Insurance Company, Inc., hereafter called the Company, or its legal representative any and all such information.

I understand the information obtained by use of this Authorization will be used by the Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application or claim or as may be otherwise lawfully required or as I may further authorize.

I understand that I may receive a copy of this authorization upon request, agree that a photographic copy of this Authorization shall be as valid as the original and agree that this Authorization shall be valid for two years from the date shown below.

The information I have provided on this form is accurate to the best of my knowledge. I have received and read the fraud warning statements provided with this form.

Signature of Beneficiary 1 _____ Date _____

Signature of Beneficiary 2 _____ Date _____

Signature of Beneficiary 3 _____ Date _____

Signature of Beneficiary 4 _____ Date _____

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NORTH AMERICAN BENEFITS COMPANY

EMPLOYER'S OR ADMINISTRATOR'S STATEMENT

(ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

FOR DISABILITY CLAIM					
Employee Name			Date of Birth		Social Security number
Occupation	Number of Hours Worked per Week		Salary		Is Disability due to Employment? ❒ Yes ❒ No
Date Employed Month/Day/Year	Date Insured Month/Day/Year		Date Last Worked Month/Day/Year		Reason for stopping Work: ❒ Disability ❒ Dismissed ❒ Leave of Absence ❒ Resigned ❒ Retired ❒ Layoff
Date Returned to Work ❒ Full-Time ❒ Part-Time Month/Day/Year Month/Day/Year	If Part-Time, Hours per day	If Employee has not returned to work, approximate week return to work date Month/Day/Year		Date employment Terminated Month/Day/Year	Date Insurance Terminated Month/Day/Year
Premium Contribution Percentage Employer _____ % Employee _____ %		If Employee contributes towards the cost of Disability coverage, please indicate if: ❒ Before, or ❒ After income is taxed			

I certify that to, the best of my knowledge, the above statements are true and correct.	
Name of Policyholder (Company)	Print Name and Title of official representative
Mailing Address of Policyholder (Company)	
Telephone Number	Fax Number
Signature	Date

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NORTH AMERICAN BENEFITS COMPANY

ATTENDING PHYSICIAN'S STATEMENT

We are in the process of evaluating a benefit claim for your patient. In order to determine benefit eligibility, we must request that this form be fully completed. This will assist our company in completing a timely review of your patient's claim. Please complete both sides of this form. This form must be completed by a physician.

Patient Name	Gender ❒ Male ❒ Female	Date of Birth	
Address	City	State	Zip Code
Policy number	Social Security number	Telephone number	

DIAGNOSIS / HISTORY

Primary diagnosis	ICD-10 code
Secondary diagnosis	ICD-10 code
Other diagnoses and ICD codes related to this condition	
List all symptoms	Date symptoms first appeared

Height	Weight	BP	Dominant Hand: ❒ Right ❒ Left

Date of first visit to you for this condition	Dates of most recent five visits	Date of next visit

Has patient ever had the same or similar condition? ❒ Yes ❒ No If Yes, indicate when and describe

Was patient referred from another physician? ❒ Yes ❒ No Is patient being treated by another physician? ❒ Yes ❒ No
If Yes to either, please provide name(s) and address(es) of the physician(s)

HOSPITALIZATION

Was patient hospitalized? ❒ Yes ❒ No If Yes, please provide the following:

Date Admitted	Admitting diagnosis	ICD-10 code
Date Discharged	Discharge diagnosis	ICD-10 code

Name of hospital	Name of doctor seen at hospital		
Address	City	State	Zip Code

Was surgery performed? ❒ Yes ❒ No If Yes, indicate procedure and date of surgery

TREATMENT PLAN

Frequency of treatment ❒ Weekly ❒ Monthly ❒ Other (specify)

Planned course of treatment (please include expected duration, surgeries, therapy, etc.)

Medications prescribed (dosage, frequency and date of prescriptions)

-- Continued --

Patient Name _____ **Date of Birth** _____

FOR ACCIDENT EXPENSE CLAIM

This condition is the result of an ❒ Illness ❒ Accident If an Accident, on what date did the Accident occur?

If an Accident, how do you understand the Accident occurred?

FOR DISABILITY CLAIM

Is condition due to an injury arising out of the patient's employment? ❒ Yes ❒ No ❒ Unknown

Objective findings (Including current X-rays, EKG's, laboratory data and any clinical findings)

Restrictions, limitations

Date accident happened _____ Date patient was unable to work because of disability _____

Date claimant will be able to perform usual work (even if considerable question exists, estimate date) ❒ Full-Time ❒ Part-Time _____

For pregnancy only: (expected) date of delivery _____ Type of delivery ❒ Vaginal ❒ C-Section

Are there any present complications or anticipated difficulties in connection with: Pregnancy ❒ Yes ❒ No Delivery ❒ Yes ❒ No Post Partum ❒ Yes ❒ No

If Yes to any, please specify in detail

Has patient: ❒ Recovered? ❒ Improved? ❒ Unchanged? ❒ Retrogressed?

Is patient: ❒ Ambulatory? ❒ House confined? ❒ Bed confined? ❒ Hospital confined? ❒ Able to drive?

FOR ACCIDENTAL DEATH AND DISMEMBERMENT CLAIM

Please document the location and extent of the injury resulting from the accident

Patient has experienced:

Loss of both hands and feet . . . . . ❒ Yes ❒ No

Loss of one hand or one foot . . . . . ❒ Yes ❒ No

Loss of one hand and one foot . . . . . ❒ Yes ❒ No

Loss of entire sight in both eyes . . . . . ❒ Yes ❒ No

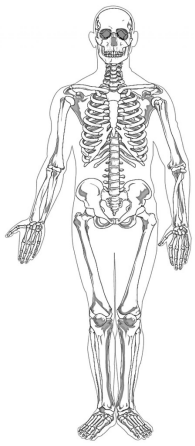
Loss of entire sight in one eye . . . . . ❒ Yes ❒ No

Loss of one hand or one foot and entire sight of one eye . . . . . ❒ Yes ❒ No

Loss of life . . . . . ❒ Yes ❒ No

Date of accident	Date of loss noted above

Please specify the exact site of the amputation or loss on the diagram below:



********** PLEASE READ CAREFULLY **********

MEDICAL RECORDS ARE REQUIRED IN ORDER FOR A PROPER REVIEW OF THIS CLAIM. PLEASE ATTACH COPIES OF ALL MEDICAL RECORDS PERTAINING TO THIS DIAGNOSIS AND TREATMENT INCLUDING LABORATORY DATA, RESULTS OF DIAGNOSTIC TESTS CONFIRMING THE DIAGNOSIS AND SEVERITY OF THE CONDITION, OFFICE VISIT NOTES, PATIENT SURGICAL REPORTS, HOSPITALIZATION RECORDS, CHART NOTES AND NARRATIVE REPORTS FROM THREE MONTHS BEFORE DISABILITY THROUGH PRESENT DATE. LACK OF MEDICAL RECORDS WILL RESULT IN A DELAY IN THE REVIEW OF THIS CLAIM AND A DELAY IN POSSIBLE PAYMENT OF BENEFITS.

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the Fraud Warnings provided with this form.

Physician's signature	**Date**

Physician's name (please print)	Specialty

Address	City	State	Zip Code

Physician Tax ID number	Phone number	Medical record department fax number

FRAUD WARNINGS

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KENTUCKY WARNING: WARNING: 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 WARNING: 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 may be guilty of a crime and subject to fines, and confinement in prison.

MAINE WARNING: 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 WARNING: WARNING: 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 WARNING: WARNING: 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 WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK 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 $5,000 and the stated value of the claim for each such violation.

OREGON WARNING: WARNING: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA WARNING: 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 subjects such person to criminal and civil penalties.

TENNESSEE WARNING: WARNING: It is a crime to knowingly supply 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 WARNING: WARNING: 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.