

## CLAIM FORM FOR PAYCHECK PROTECTION PLUS

The claimant is to complete the statement on this page and sign the second page of the form. The physician should complete the statement on the second page. Submit itemized bills.

**CLAIMANT'S STATEMENT**

POLICY NUMBER:

▲ ▲ ▲ ▲ COMPLETE IN FULL OR FORM WILL BE RETURNED ▲ ▲ ▲ ▲

1.	Insured Name:		DOB:	SSN:	
	Address:		State:	Zip:	
	City:		Phone:		
2.	Patient Name:			Patient's DOB:	
	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other				
3.	Patient's Employer:		Current Occupation:		
	Address of employer:				
	Telephone number of employer:		Job Duties:		
4.	Did the patient have an accident? <input type="checkbox"/> yes <input type="checkbox"/> no				
	Date of accident:		Time:	Date Work Stopped:	
				Time:	
	Where did the accident occur?				
	Describe accident:				
5.	Describe injuries in detail:				
	Has the patient had a similar injury within the past 2 years? <input type="checkbox"/> yes <input type="checkbox"/> no				
	Date of first medical treatment:		Time:		
	Name and address of physician:				
6.	Was the patient confined to a hospital for at least 24 hours? <input type="checkbox"/> yes <input type="checkbox"/> no				
	If yes, provide name and address of hospital:				
	Admission date:		Discharge date:		
7.	Did this claim happen on the job? <input type="checkbox"/> yes <input type="checkbox"/> no				
	Was a claim filed with patient's employer for worker's compensation benefits? <input type="checkbox"/> yes <input type="checkbox"/> no				
	If yes, send a copy of the documents filed for worker's compensation benefits.				
8.	Total disability from usual occupation from:		to:		
	Has the patient returned to work? <input type="checkbox"/> yes <input type="checkbox"/> no				
	If still disabled, what date does the patient expect to resume work?				
9.	If injury was due to a motor vehicle accident, send a copy of the police report.				
	List all medical treatment patient has received during the past 3 years:				
	Doctor/Hospital		Dates		Condition/Diagnosis

**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 information concerning material thereto, commits a fraudulent insurance act which may subject such person to criminal and civil penalties (not enforceable in Oregon, Virginia, New Jersey and Florida).

▲ ▲ ▲ ▲ SIGN AND DATE THE SECOND PAGE OF THIS FORM ▲ ▲ ▲ ▲

I hereby authorize any physician, medical practitioner, hospital, clinic, Health Maintenance Organization, including Mayo, Kaiser Foundation, Veterans Administration, or other medical or medically related facility, insurance company, or other person, organization or institution, that has any record or knowledge of me or my dependents, to give Colorado Bankers Life Insurance Company or its reinsurer any records or knowledge of my health, medical history or physical condition, including psychiatric histories, to sue for claims investigative purposes and further, to testify as to such information. This authorization is valid for thirty (30) months after the date it was signed. A photo copy of this authorization will be as valid as the original, and I or my representative can obtain a copy on request.

Insured's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ATTENDING PHYSICIAN'S STATEMENT**  
Must be completed by Physician

1.	Diagnosis:		
2.	Is the patient's condition the result of an accident? <input type="checkbox"/> yes <input type="checkbox"/> no		
3.	Is condition due to injury arising out of patient's employment? <input type="checkbox"/> yes <input type="checkbox"/> no		
4.	Report of Services (Attach Itemized Bill)		
	<b>Date of Services</b>	<b>Place of Services</b>	<b>Description of Surgical or Medical Services Rendered</b>
			<b>Procedure Code (if used)</b>
5.	Date symptoms first appeared or accident happened?		
6.	Date patient first consulted you for this condition:		
	If patient was referred to you, provide name and address of referring physician:		
7.	Has patient ever had same or similar condition? <input type="checkbox"/> yes <input type="checkbox"/> no   If so, when?		
8.	Is patient still under your care for this condition? <input type="checkbox"/> yes <input type="checkbox"/> no   If no, when was last treatment date?		
9.	a. Patient was continuously totally disabled (unable to work) from:		to:
	b. For any occupation? <input type="checkbox"/> yes <input type="checkbox"/> no		
10.	a. Patient was partially disabled from:		to:
	b. For any occupation? <input type="checkbox"/> yes <input type="checkbox"/> no		
	c. For his/her regular occupation? <input type="checkbox"/> yes <input type="checkbox"/> no		
11.	Is there any other information regarding the patient's health that we should be aware of?		

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name, Address, and Telephone:

\_\_\_\_\_

\_\_\_\_\_

# FRAUD WARNING NOTICE

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Various states impose penalties for misrepresentation of information in order to obtain insurance benefits. Before completing the attached claim forms, read your state's fraud warning in the listing below.

**ALASKA, DELAWARE, IDAHO, INDIANA, MINNESOTA, NEW HAMPSHIRE, OHIO AND OKLAHOMA** – “Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.”

**ARKANSAS AND 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.”

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

**CALIFORNIA** – “For your protection California law requires the following to appear on this form: 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.”

**DISTRICT OF COLUMBIA, MAINE, TENNESSEE AND 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 may include imprisonment, fines or a denial of insurance benefits.”

**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.”

**HAWAII** – “For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.”

**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.”

**NEW JERSEY, NEW MEXICO AND 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.”

**ALL OTHER STATES** – “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.”