

IMPORTANT - TO GET FAST CLAIM SERVICE BE SURE TO:
 1. LIST ALL POLICY/CERTIFICATE NUMBERS
 2. ANSWER ALL QUESTIONS
 3. PATIENT SIGNS THE AUTHORIZATION
 4. SEND COPIES OF ALL BILLS COVERED BY YOUR INSURANCE
 5. MAIL THIS AND BILLS TO:
BANKERS LIFE AND CASUALTY COMPANY
PO BOX 1936 CARMEL, IN 46082-1936

PATIENT'S CLAIM FORM

TO BE COMPLETED BY INSURED

1. LIST ALL BANKERS POLICY/CERTIFICATE NUMBERS NO. _____ NO. _____ NO. _____			SOCIAL SECURITY NUMBER _____	
2. INSURED'S NAME _____			3. PHONE NO.(AREA CODE) _____	
4. ADDRESS (STREET,CITY,STATE,ZIP CODE) - IF ADDRESS IS NEW PLEASE CHECK BOX <input type="checkbox"/>				
5. PATIENT'S NAME _____		6. PATIENT'S OCCUPATION _____	7. BIRTH DATE ____/____/____	8. HEIGHT ____
9. WEIGHT ____		10. PATIENT'S EMPLOYER _____		
11. EMPLOYER'S ADDRESS (STREET,CITY,STATE,ZIP CODE) _____				
12. DATE YOU FIRST BECAME ILL MONTH _____ DAY _____ YEAR _____		13. DATE OF ACCIDENT MONTH _____ DAY _____ YEAR _____		14. DATE YOU FIRST SAW ANY DOCTOR FOR THIS CONDITION MONTH _____ DAY _____ YEAR _____
15. DOCTOR'S NAME AND ADDRESS (STREET,CITY,STATE,ZIP CODE) _____				
16. IF ACCIDENT, HOW DID IT HAPPEN? _____				
17. DID YOU OR WILL YOU FILE A WORKMEN'S COMPENSATION CLAIM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
18. IN HOSPITAL, NAME: _____ DATES: FROM _____ TO _____			19. IN NURSING HOME, NAME: _____ DATES: FROM _____ TO _____	
20. REGULAR FAMILY DOCTOR'S NAME & ADDRESS (STREET,CITY,STATE,ZIP CODE) _____				
21. IS THE PATIENT COVERED BY ANOTHER HOSPITAL/MEDICAL COVERAGE? YES <input type="checkbox"/> IF SO, LIST NAME OF COMPANY AND ADDRESS. NO <input type="checkbox"/>			POLICY NUMBER _____	
22. IF CHILDBIRTH BABY'S NAME _____ SEX F <input type="checkbox"/> M <input type="checkbox"/> DATE OF BIRTH,MONTH _____ DAY _____ YEAR _____				

COMPLETE THIS SECTION IF YOU HAVE DISABILITY INCOME INSURANCE

23. WERE YOU DISABLED? YES <input type="checkbox"/> NO <input type="checkbox"/> LAST DATE WORKED _____		24. UNABLE TO WORK FULL TIME FROM _____ TO _____	25. WORKED PART TIME FROM _____ TO _____
26. DATE YOU WERE PHYSICALLY ABLE TO START WORK <div style="display: flex; justify-content: space-between;"> FULL TIME MONTH _____ DAY _____ YEAR _____ PART TIME MONTH _____ DAY _____ YEAR _____ </div>			

AUTHORIZATION: I HEREBY AUTHORIZE ANY MEDICAL PROFESSIONAL, HOSPITAL, OR OTHER MEDICAL-CARE-INSTITUTION, INSURANCE SUPPORT ORGANIZATION, GOVERNMENTAL AGENCY, INSURANCE COMPANY, EMPLOYER, OR OTHER ORGANIZATION, INSTITUTION OR PERSON THAT HAS ANY INFORMATION, RECORDS OR KNOWLEDGE OF ME OR MY HEALTH TO FURNISH TO BANKERS LIFE AND CASUALTY COMPANY OR ITS REPRESENTATIVES AND PERMIT THEM TO EXAMINE AND COPY ANY INFORMATION. I UNDERSTAND THAT SUCH INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATING MY CLAIM FOR INSURANCE BENEFITS AND THAT I ACKNOWLEDGE THAT I OR MY AUTHORIZED REPRESENTATIVE HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION UPON REQUEST. A COPY OF THIS AUTHORIZATION, OR THE ORIGINAL SHALL BE VALID FROM THE DATE SIGNED FOR THE DURATION OF THE CLAIM OR THE TERM OF THE COVERAGE.

**IMPORTANT
PLEASE
SIGN**

SIGNATURE _____ DATE _____
 (PATIENT/GUARDIAN IF MINOR)
 ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

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FRAUD WARNING NOTICES

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NOTICE: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALASKA, DELAWARE, FLORIDA, IDAHO, NEW YORK: Your state requires us to notify you that: 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 as further defined by your state statute.

ARKANSAS, HAWAII, LOUISIANA, MAINE, NEW MEXICO, RHODE ISLAND, TENNESSEE, TEXAS, VIRGINIA, 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.

ARIZONA, KENTUCKY, OHIO: WARNING: 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.

CALIFORNIA: For your protection California law requires the following warning statement 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: any person who knowingly and with intent to defraud an insurer provides false, incomplete or misleading information is subject to criminal and civil penalties, including imprisonment, fines and denial of insurance. Any agent who knowingly and with intent to defraud a policyholder or claimant provides false, incomplete or misleading information with regard to a settlement or insurance proceeds payable will be reported to the Colorado Insurance Department.

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.

INDIANA, MINNESOTA: Your state requires us to notify you that: any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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: Your state requires us to notify you that any person, 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 under New Hampshire law.

NEW JERSEY, PENNSYLVANIA: NOTICE: 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.

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.

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 with the penalty of 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.

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.

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