National Union Fire Insurance Company

Chartis Accident & Health **P. O. Box 25987** **Shawnee Mission, KS 66225** **1-800-617-2836 (Telephone)** **1-866-893-8574 (Facsimile)**	**PROOF OF LOSS** **POLICYHOLDER: NASE** **MASTER POLICY NUMBER: 9131330**

CRITICAL ILLNESS CLAIM FORM

INSTRUCTIONS:

1.) This form is to be used when filing for reimbursement of Annual Preventative Care Benefit or Lump Sum Critical Illness Benefit
2.) For Preventative Care Benefit, Section A must be completed by the Insured in full. A copy of office visit or lab results must be attached
3.) For Lump Sum Benefit, Section A must be completed by the Insured in full. Section B must be fully completed by the Attending Physician.
4.) This form must be signed and dated in all applicable sections.
5.) This form must be submitted to the address indicated above.
The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A

Coverage Effective Date: / /	Coverage Termination Date: / /	Certificate Number:
1) Name of Insured:(please print)	Date of Birth: / /	Sex: ☐Male / ☐ Female
2) Name of Claimant:(please print)	Date of Birth: / /	Sex: ☐Male / ☐ Female
3) Address:	Social Security Number:	U. S. Citizen ☐Yes ☐ No
City:	State:	Zip Code:

4) Telephone Number (Daytime): ( ) -

5) Dates Hospitalized:	From:	To:

6) Advise nature of sickness and when and where symptoms first occurred:

7) Name of Consulting Physician(s):	Street Address:	
City:	State:	Zip Code:

8) Have you ever been treated for this or a related / similar illness: ☐ Yes / ☐ No

If Yes, provide:	Date(s) first consulted Physician(s):	Name of Physician(s):

Street Address:

City:	State:	Zip Code:
9) Provide Name of Regular Physician:	Street Address:	
City:	State:	Zip Code:

10) Please advise names of any prescription medications you are presently taking:

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

California: 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**.**

Rhode Island : 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

For residents of New York: 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, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

For residents of Pennsylvania: 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 and subjects such person to criminal and civil penalties.

For claimants not residing in California, Rhode Island, New York, or Pennsylvania: 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.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF CLAIMANT OR PARENT, IF CLAIMANT IS A MINOR	DATE

Section B: Attending Physician's Statement

Patient's Name:	Date of Birth:

1) Diagnosis, chief complaint, history, complications:

2) Dates the patient received medical attention for the above condition:

3) Dates Hospitalized	From:	To:

4) Name of Hospital:	Address:

City:	State:	Zip Code:

5) Surgery performed (if applicable):

6) Name of Referring Physician:	Address:

City:	State:	Zip Code:

7) Has patient ever had same or similar condition? ☐ Yes (If yes, give date and describe) / ☐ No

8) Have you previously treated this patient? ☐ Yes (If yes, five date and illness treated) / ☐ No

9) Does patient suffer from any chronic illnesses? ☐ Yes (If yes, identify illnesses) / ☐ No

10) Does patient take any prescription medication regularly? ☐ Yes (If yes, identify medications) / ☐ No

I HEREBY CERTIFY THAT THE ABOVE INFROMATIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

11) Signature of Physician Including Degrees of Credentials:

Signature:	Date:

12) Name of Facility Where Services Were Rendered (If other than home or physician's office):

Name:	Address:

City:	State:	Zip Code:

13) Physician's Name:	Address:

City:	State:	Zip Code:	Telephone Number: