

# HOSPITAL INDEMNITY CLAIM FORM

## INSTRUCTIONS:

- You should complete all sections and sign the Member Certification. **COMPLETION** of the entire form speeds claims processing.
- Please make sure that you sign the Authorization for Release of Information on the reverse side of this claim.
- Have your provider of service complete the Physician or Supplier Information Section on the reverse side of this form.

**MAIL COMPLETED FORM AND ANY ITEMIZED BILLS TO:**  
AMA INSURANCE AGENCY, INC.  
330 N. Wabash Ave, Suite 39300  
CHICAGO, IL 60611-5885  
(800) 458-5736

## CLAIM PROCESSING INFORMATION (COMPLETE BY MEMBER)

<b>Name</b>	<input type="text"/>	Social Security Number:	<input type="text"/>
<b>Address</b>	<input type="text"/>		
<b>City</b>	<input type="text"/>	State	<input type="text"/>
		Zip Code	<input type="text"/>
<b>Phone Number</b>	<input type="text"/>		
<b>Date of Birth</b>	<input type="text"/>	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Marital Status</b>	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Are you or any of your family members covered through any other plans which provide hospital indemnity benefits?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, provide information requested below:			
<b>Other Carrier's Name:</b>	<input type="text"/>		
<b>Address:</b>	<input type="text"/>		
<b>Phone Number:</b>	<input type="text"/>		
<b>Name of Covered Person:</b>	<input type="text"/>		
<b>Plan Number:</b>	<input type="text"/>		
<b>On What Date Did Symptoms First Appear?</b>	<input type="text"/>		
<b>Name and address of physicians and/or medical facilities treating the patient:</b>			
<input type="text"/>			
<b>Name and address of hospital where confined:</b>			
<input type="text"/>			
<b>Dates of Hospital Confinement:</b>			
From:	<input type="text"/>	To:	<input type="text"/>
From:	<input type="text"/>	To:	<input type="text"/>
<b>Nature of sickness or injury:</b>			
<input type="text"/>			
<b>On what date did the patient first consult or receive medical treatment from a physician for this illness or accident?:</b>			
<input type="text"/>			

## PATIENT INFORMATION

<b>Patient's Name:</b>	<input type="text"/>	Social Security Number:	<input type="text"/>
<b>Address:</b>	<input type="text"/>		
<b>Patient's Relationship To Member</b>	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		
<b>Patient's Sex:</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female		
<b>Date of Birth:</b>	<input type="text"/>		
<b>If claim is for dependent child, when charges were incurred, was child:</b>			
<b>Married?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>In The Military?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Employed?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Federal Employee?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

## PATIENT INFORMATION

I CERTIFY: I HAVE READ AND UNDERSTAND THE FRAUD STATEMENT THAT IS APPLICABLE TO THE STATE IN WHICH I RESIDE. ANY PERSON WHO KNOWINGLY AND WITH THE 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.

New York Residents: Any person who knowingly and with the 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 five thousand dollars and the stated value of the claim for each such violation.

I CERTIFY THAT THE INFORMATION SHOWN ABOVE IS COMPLETE AND ACCURATE.

MEMBER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(SIGNATURE OF DEPENDENT SPOUSE IS NOT ACCEPTABLE)

**AUTHORIZATION FOR RELEASE OF INFORMATION (COMPLETED BY PATIENT)**

*TO: All providers of medical services and supplies, employers, insurance institutions and other organizations.*

*I authorize release to New York Life Insurance Company and any independent claim administrators, consulting health professionals and utilization review organizations with whom New York Life has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. This authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this authorization at any time by notifying the Administrator in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person has already disclosed or collected information or taken other action in reliance on it. The information New York Life obtains through this authorization may become subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.*

*A photocopy of this authorization and request form shall be as valid as the original. I know that I may request a copy of this authorization.*

\_\_\_\_\_  
PATIENT'S SIGNATURE (PARENT'S/GUARDIAN IF MINOR)

\_\_\_\_\_  
DATE

**PHYSICIAN OR SUPPLIER INFORMATION (MUST BE COMPLETED IN FULL BY PROVIDER OF SERVICE)**

Date of Current  ILLNESS (FIRST SYMPTOM) OR

INJURY (ACCIDENT) OR

PREGNANCY (LMP)

Diagnosis or nature of illness or injury:

Date first consulted you for this Condition:

Has patient ever had same or similar symptoms?  Yes  No

If yes, give first date:

Is condition due to pregnancy?  Yes  No

Hospitalization dates related to current services:

From:

Through:

If yes, give approximate date pregnancy commenced.

Name of Referring Physician

Physician's or Supplier's Billing Name, Address, Zip & Phone#

Federal Tax I.D. Number

SSN  EIN

Signature\_\_\_\_\_

Date\_\_\_\_\_

**PLEASE REMEMBER TO ATTACH YOUR HOSPITAL BILL TO THIS CLAIM FORM AND MAIL TO THE ADDRESS ON THE REVERSE SIDE OF THIS FORM.**