

# HOSPITAL INDEMNITY CLAIM FORM

## INSTRUCTIONS

- **COMPLETE** the Member Information Section for all claims.
- Complete the Patient Information Section when submitting a claim for a covered dependent.
- Always sign and date the Member Certification.
- Always sign and date the Authorization for Release of Information. If the claim is for a dependent, the patient or patient's parent/guardian must sign and date.
- Attach all itemized bills.

MAIL COMPLETED FORM AND  
ANY ITEMIZED BILLS TO:  
AVMA LIFE TRUST PROGRAM  
ADMINISTRATOR  
1200 E. Glen Ave  
Peoria Heights, IL 61616  
1-(800)-621-6360

### MEMBER INFORMATION

▶ MEMBER'S LAST NAME: _____ FIRST NAME: _____ INITIAL: _____	▶ SOCIAL SECURITY NUMBER _____/_____/_____
STREET ADDRESS: _____	▶ NAME AND ADDRESSES OF PHYSICIANS AND/OR MEDICAL FACILITIES TREATING THE PATIENT: _____ _____
CITY: _____ STATE: _____ ZIP CODE: _____	_____ _____
DAYTIME TELEPHONE NUMBER: ( ) _____	▶ NAME AND ADDRESS OF HOSPITAL WHERE CONFINED: _____ _____
▶ DATE OF BIRTH: MONTH ___ DAY ___ YEAR ___ ▶ SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	▶ DATES OF HOSPITAL CONFINEMENT: FROM _____ TO _____ FROM _____ TO _____ FROM _____ TO _____
▶ MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	▶ NATURE OF SICKNESS OR INJURY: _____ _____
▶ 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:	▶ ON WHAT DATE DID THE PATIENT FIRST CONSULT OR RECEIVE MEDICAL TREATMENT FROM A PHYSICIAN FOR THIS ILLNESS OR ACCIDENT? MONTH ___ DAY ___ YEAR _____
OTHER CARRIER'S NAME: _____	
ADDRESS: _____	
TELEPHONE NUMBER: _____	
NAME OF COVERED PERSON: _____	
PLAN NUMBER: _____	
▶ ON WHAT DATE DID SYMPTOMS FIRST APPEAR? MONTH ___ DAY ___ YEAR _____	

### PATIENT INFORMATION

▶ LAST NAME: _____ FIRST NAME: _____ INITIAL: _____	▶ PATIENT SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
▶ STREET ADDRESS: (IF DIFFERENT FROM MEMBER'S ADDRESS) _____	▶ DATE OF BIRTH: MONTH ___ DAY ___ YEAR _____
CITY: _____ STATE: _____ ZIP CODE: _____	▶ SOCIAL SECURITY NUMBER _____/_____/_____
▶ PATIENT'S RELATIONSHIP TO MEMBER: <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> OTHER _____	▶ IF CLAIM IS FOR DEPENDENT CHILD, WHEN CHARGES WERE INCURRED, WAS CHILD: MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO IN THE MILITARY? <input type="checkbox"/> YES <input type="checkbox"/> NO FEDERAL EMPLOYEE? <input type="checkbox"/> YES <input type="checkbox"/> NO

### MEMBER CERTIFICATION

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 FRAUD 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: \_\_\_\_\_

### 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