Family Heritage Life Insurance Company of America

P.O. Box 470608 Cleveland, Ohio 44147

Please read the following information before completing this form.

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive 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.

Arkansas, Louisiana, Rhode Island, Texas and 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.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim 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 information to obtain or amend insurance coverage or to make a 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: 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.

Florida: Any person who knowingly or 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 any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Indiana: 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.

Kentucky: Any person who knowingly or 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.

Maine: 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.

Minnesota: Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, 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, as provided in RSA 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false of fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: 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.

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.

Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

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.

Tennessee, Virginia and 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.

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

P.O. Box 470608, Cleveland, OH 44147-9998, (440) 922-5151

HOSPITAL CONFINEMENT CLAIM FORM

IMPORTANT: <u>All</u> questions must be answered on side 1 by the Claimant and side 2 by the treating physician. A claim form and hospital bill must be submitted for <u>each</u> confinement. When applicable, hospital admission/discharge summaries, medical records and/or a police report may be required.

Policyholder's Name:		Policy No.:	

Claimant's Name: _____ Social Security No.: _____

Address: _____

Phone No.: _____ Date of Birth: _____

Relationship to the policyholder: ☐ self ☐ spouse ☐ son ☐ daughter ☐ other _____

Describe reason the patient was hospitalized: _____

_____

If hospitalized due to a medical condition, provide the date this condition was diagnosed: _____

Has the patient ever been diagnosed with this condition prior to this confinement? ☐ Yes ☐ No

If Yes, the date diagnosed: _____

If hospitalized due to an accident, describe how the injury occurred: _____

_____

Date Accident Occurred: _____ Place Accident Occurred: _____

Name and phone number of all treating physicians, including family physician:

_____

_____

_____

Name, address and phone number of the hospital (a hospital bill listing all dates must be included with form):

_____

_____

_____

IMPORTANT NOTICE: Any person who, knowingly facilitates a fraud or has an intent to defraud an insurer, or submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud.

AUTHORIZATION MUST BE SIGNED BEFORE A CLAIM CAN BE PROCESSED

I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau to furnish any information with respect to any illness or accident, medical history or medical records for the Patient to Family Heritage Life Insurance Company of America or its representative for the purpose of evaluating claims for benefits. I understand that this authorization is voluntary and I may revoke it at any time by submitting a written revocation to Family Heritage Life Insurance Company of America. If I do revoke this authorization, it will not have any affect on any information released before Family Heritage Life Insurance Company of America's receipt of the revocation, including any action taken by the individual/entity that received the health information. I further understand that I may request to see and copy the information described in this Authorization and that I am entitled to a signed copy of this Authorization. I acknowledge that unless an earlier date is specified under applicable law, this Authorization will expire 90 days from the date signed.

Signed _____ **Date:** _____

Claimant, Parent (If Child) or Executor

IF THE CLAIMANT IS UNABLE TO PROVIDE A SIGNATURE, PLEASE INCLUDE A COPY OF A POWER OF ATTORNEY, LETTER OF EXECUTOR AND/OR DEATH CERTIFICATE

Patient's Name _____ Policy #_____

PHYSICIAN'S STATEMENT TO BE COMPLETED AND SIGNED BY THE TREATING PHYSICIAN

Reason for Hospital Confinement: _____

Admission Date: _____ Discharge Date: _____

Diagnosis: _____ Diagnosis Codes: _____

Do you have records on the patient's past medical history? □ Yes □ No

Was the patient hospitalized solely due to this condition? □ Yes □ No

Has the patient ever had the same or similar condition? □ Yes □ No

If Yes, date Diagnosed: _____

Was the condition due to an accident? □ Yes □ No

If Yes, date of accident: _____

Describe the nature of the injury or condition: _____

_____

Describe any other disease or infirmity affecting present condition: _____

_____

Was the patient under the influence of any intoxicant or narcotic? □ Yes □ No

If Yes, was it under the direction of a physician? □ Yes □ No

If Yes, please explain: _____

_____

Did the intoxicant or narcotic contribute to the patient's injury or condition? □ Yes □ No

If Yes, please explain: _____

_____

List any applicable procedure codes: _____

Physician's Information:

Physician's Name: _____

Specialty: _____

Address and Phone Number: _____

Completed by (please print): _____ Position/Title: _____

Physician's Signature: _____ **Date:** _____