



United National Life Insurance Company of America
P.O. Box 1154 • Glenview, IL 60025-1154
Claim Department Phone Number: 800-207-8050
FAX Number: 847-699-0229

Please show ALL UNL Policy Numbers here:

1. _____
2. _____
3. _____

PATIENT'S STATEMENT

PLEASE NOTE: IT IS IMPORTANT THAT ALL QUESTIONS BE ANSWERED IN FULL AND THAT THIS FORM BE RETURNED TO THE COMPANY. IF PATIENT IS A MINOR, QUESTIONS SHOULD BE COMPLETED BY THE INSURED. IF CLAIM IS FOR HOSPITAL OR DOCTOR EXPENSES PLEASE ATTACH ITEMIZED BILLS.

PATIENT'S CLAIM FORM

1. INSURED'S NAME:	2. ALTERNATE NAME:	3. PHONE NO.: ()
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4. ADDRESS (Street, City, State, ZIP Code) – IF ADDRESS IS NEW, PLEASE CHECK BOX

5. PATIENT'S NAME (if other than the Insured):	6. PATIENT'S OCCUPATION:	7. BIRTH DATE ____ / ____ / ____
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8. DATE PATIENT BECAME ILL OR DATE OF ACCIDENT: ____ / ____ / ____

8a. IF ACCIDENT, HOW DID IT HAPPEN?:

9. DATE PATIENT FIRST SAW ANY DOCTOR FOR THIS CONDITION?: ____ / ____ / ____

9a.. WERE YOU EVER SICK WITH THIS CONDITION BEFORE?: YES NO

9b. IF YES, WHEN: ____ / ____ / ____

10. DOCTOR'S NAME & ADDRESS (Street, City, State, ZIP Code):

11. DID YOU OR WILL YOU FILE A WORKMEN'S COMPENSATION CLAIM?: <input type="checkbox"/> YES <input type="checkbox"/> NO	11a. IF YES, WHAT IS THE EMPLOYERS NAME & ADDRESS (Street, City, State, ZIP Code):
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12. IN HOSPITAL, NAME & ADDRESS (Street, City, State, ZIP Code):

13. IN NURSING HOME, NAME & ADDRESS (Street, City, State, ZIP Code):

14. FAMILY DOCTOR NAME & ADDRESS (Street, City, State, ZIP Code):

15. OTHER DOCTORS SEEN DURING THE LAST 2 YEARS:

16. IF CHILDBIRTH, LIST BABY'S NAME BELOW:

Full Name: MALE FEMALE DATE OF BIRTH: ____ / ____ / ____

I understand that this information will be used by United National Life Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.
Be sure to sign below AND the attached authorization.

Name of Patient

Signature of Patient Authorized Representative, or Next of Kin

Date Signed (Month Day Year)

(If Patient is under eighteen (18) years of age or is incapacitated, parent or Guardian must sign. IF PATIENT IS DECEASED, Personal Representative or Next of Kin must sign.) **The furnishings of the form is not admission of any Liability on the part of the Company.**

PHYSICIAN'S STATEMENT

PATIENTS & INSURED INFORMATION

1. INSURED'S NAME (First name, middle int., last name) ALTERNATE NAME	2. PATIENT'S NAME (If other than the insured - First name, middle int. last name):	3. PATIENT'S DATE OF BIRTH ____ / ____ / ____
4. PATIENT'S RELATIONSHIP TO INSURED: SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	5. INSURED'S I.D. MEDICARE &/OR MEDICAID:	6. INSURED'S POLICY NUMBER:
7. DATE OF ILLNESS (FIRST SYMPTOM OR INJURY (ACCIDENT) OR PREGNANCY)	8. DATE FIRST CONSULTED YOU FOR THIS CONDITION ____ / ____ / ____	9. HAS PATIENT HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>
11. IF PATIENT HAS OTHER HEALTH INSURANCE COVERAGE, LIST COMPANY & POLICY NUMBER		10. IF AN EMERGENCY CHECK HERE <input type="checkbox"/>
12. IS THIS INJURY OR SICKNESS WORK RELATED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		14. FOR SERVICES RELATED TO HOSPITALIZATION GIVEN HOSPITALIZATION DATES ADMITTED DISCHARGED
15. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		16. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES

17. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN **COLUMN D** BY REFERENCE NUMBERS 1,2,3 ETC OR DX CODE (ICDA9)

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|----|----|
| 1. | 3. |
| 2. | 4. |

18. A. DATE OF SERVICE	*B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (CPT) (IDENTIFY) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS-CODE	E. CHARGES	F. DAYS OR UNITS	G. ** TYPE OF SERVICE	H.

19. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____ DATE _____	20. ACCEPT ASSIGNMENT YES <input type="checkbox"/> NO <input type="checkbox"/>	21. TOTAL CHARGE	22. AMOUNT PAID	23. BALANCE DUE
24. YOUR SOCIAL SECURITY NO.	25. PHYSICIANS OR SUPPLIERS NAME, ADDRESS, ZIP CODE, & TELEPHONE NO. I.D. Number.			
26. YOUR PATIENTS ACCOUNT NO.	27. YOUR EMPLOYER I.D. NO.			

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| *PLACE OF SERVICE CODES:
1-(IH) -INPATIENT HOSPITAL
2-(OH) -OUTPATIENT HOSPITAL
3-(O) -DOCTOR'S OFFICE
4-(H) -PATIENT'S HOME
5- -DAY CARE FACILITY (PSY) | 6- -NIGHT CARE FACILITY (PSY)
7-(NH) -NURSING HOME
8-(SNF) -SKILLED NURSING FACILITY
9- -AMBULANCE
0-(OL) -OTHER LOCATIONS
6-RADIATION THERAPY
7-ANESTHESIA
8-ASSISTANCE AT SURGERY
9-OTHER MEDICAL SERVICE
0-BLOOD OR PACKED RED CELLS | A- -INDEPENDENT LABORATORY
B- -OTHER MEDICAL/SURGICAL FACILITY
C-(RTC) -RESIDENTIAL TREATMENT CENTER
D-(STF) -SPECIALIZED TREATMENT FACILITY

A-USED DME
M-ALTERNATE PAYMENT FOR MAINTENANCE DIALYSIS
Y-SECOND OPINION ON ELECTIVE SURGERY
Z-THIRD OPINION ON ELECTIVE SURGERY |
| **TYPE OF SERVICE CODES
1-MEDICAL CARE
2-SURGERY
3-CONSULTATION
4-DIAGNOSTIC X-RAY
5-DIAGNOSTIC LABORATORY | | |

Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.

**Alabama
Arkansas
California
Connecticut
Georgia
Iowa
Illinois
Kansas**

**Louisiana
Massachusetts
Maryland
Michigan
Missouri
Mississippi
Montana
North Carolina**

**North Dakota
Nebraska
Nevada
Puerto Rico
Rhode Island
South Carolina
South Dakota**

**Texas
Utah
Vermont
Wisconsin
West Virginia
Wyoming**

Generic Fraud Warning (to be used for above states only)

Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alaska, Delaware, Idaho, Indiana, Oklahoma

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

Colorado, D.C., Hawaii, Maine, Tennessee, Virginia

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 coverage.

Arizona, Minnesota, New Jersey, New Mexico

IN 12 POINT TYPE FOR ALL STATES LISTED TO SATISFY ARIZONA REQUIREMENTS

Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

Kentucky, Ohio, Oregon

Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

Florida

Any person who, knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section 817.234 F.S.

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.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files 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.

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.

**UNITED LIFE INSURANCE COMPANY OF AMERICA
P. O. Box 1154, Glenview, Illinois 60025-1154
1-800-207-8050**

HIPAA AUTHORIZATION
To Permit Use and Disclosure of Health Information

This Authorization was prepared by UNL for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide United National Life Insurance Company of America (UNL) or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that United National Life Insurance Company of America may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by UNL in accordance with federal or state law.

This Authorization is valid from the date signed for the duration of the claim.

(Print Please) Name of Patient

Signature of Patient and Date

(Please Print) Name of Authorized Representative, or Next of Kin

Relationship of Authorized Representative or Next of Kin to Patient

Signature of Authorized Representative or Next of Kin Date

Social Security # _____

Policy # _____