MEDMUTUAL LIFE®
100 American Road
Brooklyn, OH 44144-2322

Large Group Claim Form

Phone: (877) 271-4094
Fax: (440) 878-6916
Email Address: Claims @ medmutual.com

Employer Name
Group Number

Type of Claim Being Submitted: ☐ Critical Illness Benefit ☐ Accident Benefit ☐ Hosptial Indemnity Benefit

Instructions:

- Complete Claimant/Patient Information and sign your claim form.
- Have the treating physician complete Physician's Statement and sign the claim form.
- If hospitalized and/or confined to an intensive care unit, please send a copy of your hospital bill showing charges and the number of days you were confined.
- If filing an accident indemnity claim, please submit copies of the itemized bills for the benefits you are claiming.

Claimant's Statement *(Please print)*

Name	Social Security No.	Sex ☐ Male ☐ Female	Date of Birth / /
Address Number Street City State Zip			Home Telephone Number
Home Email Address (optional)			

Patient Information *(Please print)*

Name	Social Security No.	Sex ☐ Male ☐ Female	Date of Birth / /
Address Number Street City State Zip			Home Telephone Number
Home Email Address (optional) _____			

Relationship to Claimant: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child ☐ Check here if dependent child is a full-time student (if over the age 19, please provide school name and contact information).

1. Date of Accident or Beginning of Sickness: _____/_____/_____
2. Nature of Illness or Injury: _____
3. If Injury, describe how and where the accident occurred: _____
4. Have you ever had same or similar illness? ☐ Yes ☐ No If yes, give dates: From _____/_____/_____ to _____/_____/_____
5. Have you filed a claim for this injury under the Worker's Compensation Act? ☐ Yes ☐ No
6. Name of Hospital(s): _____ Confined From _____/_____/_____ to _____/_____/_____
   Address of Hospital(s): _____
7. Name and Address of Doctor(s): _____

I authorize my employer to access and/or disclose any information necessary to process my claim to MedMutual Life Insurance Company (MMLI). I hereby authorize any medical professional, hospital, medical facility, medical provider, clinic, pharmacy, Government Agency, Insurance Company or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to MMLI's claim department or its authorized representative(s) information about my medical history or treatment for any condition, including but not limited to drug or alcohol abuse, mental illness, HIV (AIDS virus) or other sexually transmitted diseases, I further authorize MMLI to disclose the information obtained in the consideration of my claim for insurance to its reinsurers.
I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on prior actions taken by MMLI;
- Information disclosed may be redisclosed and no longer protected by federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy is as valid as the original;

I, as well as any other person authorized to act on my behalf, acknowledge the right upon request to obtain a true copy of my authorization from MMLI.
If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, MMLI has the right to deny my claim.
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 THERE TO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. (Not enforceable in Oregon or Virginia.)

_____ Signature of Claimant

_____ Date

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Attending Physician's Statement *(Please print)*

(Must be completed in full at no expense to MedMutual Life)

Patient's Name	Address	Date of Birth / /	Sex ☐ Male ☐ Female

1. Symptoms result from : ☐ Injury ☐ Illness
2. Diagnosis and complications, if any: _____ ICD9-CM_____
3. Date symptoms first appeared or date of accident: _____/_____/_____ 4. Is condition work related? ☐ Yes ☐ No
5. Date patient first consulted you for this condition: _____/_____/_____ 6. Most recent treatment date: _____/_____/_____
7. Describe any other disease or complication affecting present condition: _____
8. Date and nature of surgical, if any: _____

Dates of Service	Procedure Code	Procedure Description

9. Has patient been hospitalized : ☐ Yes ☐ No If yes, was patient confined to Intensive Care Unit: ☐ Yes ☐ No
   If yes, dates of confinement: _____/_____/_____ to _____/_____/_____
10. Name and address of hospital: _____
11. Has the patient ever had the same or similar condition: ☐ Yes ☐ No If yes, state when and describe: _____
12. Is patient still under your care: ☐ Yes ☐ No If no, give discharge date and degree of recovery: _____
13. Is patient under the care of another physician? ☐ Yes ☐ No If yes, name and address: _____
14. Did the patient receive blood or plasma within 90 days of the covered accident? ☐ Yes ☐ No _____
15. Did the patient require the use of a prosthetic device? ☐ Yes ☐ No If yes, please indicate what prosthetic device: _____
16. Was the patient advised to use a medical appliance such as, walker, brace, crutches, etc.? ☐ Yes ☐ No If yes, what medical appliance was advised: _____

Physician Signature: _____ Date: _____/_____/_____

Name *(Please Print)*: _____ Specialty: _____

Address: _____

Telephone Number: _____ Fax Number: _____

MEDMUTUAL LIFE®
A Medical Mutual Company

Fraud Notices

The laws of some states require us to furnish you with the following notice:

For residents of all states except California, Florida, New Jersey, New York, Pennsylvania, Utah, Vermont, Virginia and Washington; WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

CALIFORNIA RESIDENTS – 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.

FLORIDA RESIDENTS – Any person knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or application containing false, incomplete or misleading information is guilty of a felony of the third degree.

NEW JERSEY RESIDENTS – Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS – 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 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.

PENNSYLVANIA AND UTAH RESIDENTS – 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 materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VIRGINIA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

WASHINGTON RESIDENTS – Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines and denial of insurance benefits.