Claim Submission Instructions for CCPOA Members

1) Be sure to complete the appropriate sections of the claim form and provide all requested information.

2) Have the physician treating you complete the Attending Physician's Statement on page 2 .

3) If loss of time is claimed, have your employer or school complete the Employer Statement on page 1.

4) If medical or hospital benefits are claimed, itemized bills must be attached. Make sure the claimant's name is on each attachment.

5) Be sure to sign the claim form on the bottom of page 1.

6) **Fax both pages of the claim form and any itemized bills to 312-351-6930**. Faxing will expedite the processing of your claim.

7) You should receive status of your claim within 7 to 10 business days of our receipt of your claim form.

Questions about your claim? Call 1-866-445-8865

P.O. Box 6700, Scranton, PA 18505-0700 • www.combinedinsurance.com
The ACE Group of Companies

COMBINED INSURANCE

COMBINED INSURANCE COMPANY OF AMERICA

P.O. Box 6700 • Scranton, PA 18505-0700

Fax both pages of this form to: 312-351-6930.

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 to state prison.

PLEASE PRINT—DO NOT WRITE

CLAIMANT'S FULL NAME ☐ MR. ☐ MRS. ☐ MISS | E-MAIL ADDRESS

PLEASE LIST OTHER NAMES THAT YOU MAY USE SUCH AS MAIDEN NAME, NICKNAME, ETC. | HOME PHONE | BUSINESS PHONE

MAILING ADDRESS (Street, City, State, Zip)

BIRTH DATE ..../........./......... MO. DAY YR. | HEIGHT | WEIGHT

POLICY NUMBER(S)	PLAN NUMBER(S)	LAST PAYMENT DATE
a)	a)	a) ..../......../........ MO. DAY YR.
b)	b)	b) ..../......../........ MO. DAY YR.
c)	c)	c) ..../......../........ MO. DAY YR.

Is claimant eligible for Medicaid or a similar state program? ☐ YES NO ☐

OCCUPATION | **CCPOA Benefit Trust Fund** | ARE YOU ALSO FILING CLAIM UNDER WORKERS' COMP. ACT? ☐ YES NO ☐

IF YOU HAVE OTHER ACCIDENT, SICKNESS OR HOSPITAL INSURANCE, GIVE COMPANY NAME

IF CLAIM IS FOR SICKNESS PLEASE COMPLETE

DATE OF FIRST SYMPTOMS ..../........./......... MO. DAY YR.

HAVE YOU EVER HAD SAME OR SIMILAR CONDITION? ☐ YES NO ☐

IF YES, GIVE DATE ..../........./......... MO. DAY YR.

NATURE OF SICKNESS

IF CLAIM IS FOR ACCIDENTAL INJURY ("ACCIDENT") PLEASE COMPLETE

DATE OF ACCIDENT ..../........./......... MO. DAY YR.

TIME OF ACCIDENT .....AM .....PM

NATURE OF INJURIES

PLEASE STATE EXACTLY WHERE YOU WERE WHEN ACCIDENT OCCURRED INCLUDING A DETAILED DESCRIPTION OF HOW ACCIDENT OCCURRED:

PLEASE COMPLETE FOR BOTH ACCIDENT AND SICKNESS CLAIMS

HOSPITAL'S NAME ....

ADDRESS .... CITY .... STATE ....

CONFINEMENT DATES: FROM ..../........./......... MO. DAY YR. TO ..../........./......... MO. DAY YR.

ATTENDING PHYSICIANS' NAMES AND ADDRESSES

DATES OF TREATMENT

........./........./......... MO. DAY YR.

........./........./......... MO. DAY YR.

A) **TOTAL DISABILITY:** BETWEEN WHAT DATES WERE YOU UNABLE TO PERFORM ANY DUTIES?

A) FROM ..../........./......... MO. DAY YR. THROUGH ..../........./......... MO. DAY YR.

B) **DATE RETURNED TO WORK**

B) ..../........./......... MO. DAY YR.

C) **PARTIAL DISABILITY:** BETWEEN WHAT DATES WERE YOU ABLE TO PERFORM ONLY PARTIAL DUTIES?

C) FROM ..../........./......... MO. DAY YR. THROUGH ..../........./......... MO. DAY YR.

EMPLOYER'S STATEMENT (If student, please have school principal complete) COMPLETE ONLY IF CLAIMING LOSS OF TIME

EMPLOYEE'S NAME

WORKERS' COMPENSATION CLAIM FILED FOR THIS DISABILITY? ☐ YES NO ☐

NAME AND ADDRESS OF COMPENSATION CARRIER

DATE RETURNED TO WORK (OR SCHOOL) ..../........./......... MO. DAY YR.

TOTAL DISABILITY: BETWEEN WHAT DATES DID EMPLOYEE GIVE UP ALL DUTIES? FROM ....../....../...... MO. DAY YR. TO ....../....../...... MO. DAY YR.

PARTIAL DISABILITY: BETWEEN WHAT DATES DID EMPLOYEE GIVE UP ONLY PART OF DUTIES? FROM ....../....../...... MO. DAY YR. TO ....../....../...... MO. DAY YR.

DATE | TITLE | EMPLOYER'S SIGNATURE | TELEPHONE

AUTHORIZATION TO RELEASE INFORMATION

I authorize any hospital, medical practitioner, medically related facility, Prescription Drug Database, insurance company, state and federal government agency, the Internal Revenue Service, employer, consumer reporting agency or the MIB (Medical Insurance Bureau) to release to Combined Insurance Company of America any information for the purpose of processing a claim. Combined is also authorized to disclose such information to any doctor. This authorization or photocopy shall be valid for the duration of the claim. A copy is available upon request.

DATED: ..../........./......... MO. DAY YR.

SIGNED: X ....
CLAIMANT'S SIGNATURE (If Minor, Parent's Signature)

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME	ADDRESS (Street, City, State, Zip)	AGE

1. NATURE AND ORIGIN OF: ☐ SICKNESS ☐ INJURY	**DIAGNOSIS** (DESCRIBE COMPLICATIONS, IF ANY) CONFIRMED BY X-RAY? ☐ YES ☐ NO
2. WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?	DATE ..../............./................ MO. DAY YR.
3. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?	DATE ..../............./................ MO. DAY YR.
4. HOW DID CONDITION ORIGINATE?	
5. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? (IF "YES", STATE WHEN AND DESCRIBE.)	☐ YES DESCRIBE CONDITION: ☐ NO
6. DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION.	
7. GIVE DATE AND NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY. (DESCRIBE FULLY AND GIVE APPROACH USED IF MORE THAN ONE IS POSSIBLE.)	DATE ..../............./................ MO. DAY YR. NATURE OF PROCEDURE: APPROACH USED: CLOSED REDUCTION? ☐ OPEN REDUCTION? ☐ METAL FIXATION? ☐
8. GIVE DATE OF TREATMENT, AND NATURE OF TREATMENT OTHER THAN SURGICAL.	DATE ..../............./................ MO. DAY YR. NATURE OF TREATMENT: OFFICE ☐ HOSPITAL ☐ HOME ☐
9. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? IF DISCHARGED, GIVE DATE, AND DEGREE OF RECOVERY.	☐ YES ☐ NO DISCHARGE DATE ..../............./................ MO. DAY YR. RECOVERED? ☐ YES ☐ NO
10. IF PATIENT HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL.	HOSPITAL .... ADDRESS ....CITY .... STATE .... FROM ..../............./................ MO. DAY YR. THROUGH ..../............./................ MO. DAY YR.
11. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED?	FROM ..../............./................ MO. DAY YR. THROUGH ..../............./................ MO. DAY YR.
12. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?	FROM ..../............./................ MO. DAY YR. THROUGH ..../............./................ MO. DAY YR.
13. IF PATIENT IS DISABLED ON DATE YOU COMPLETE THIS FORM, IS THERE A RETURN TO WORK DATE? (IF "YES", GIVE RETURN TO WORK DATE.)	☐ YES RETURN TO WORK DATE ..../............./................ MO. DAY YR. ☐ NO

PHYSICIAN'S SIGNATURE	DEGREE
COMPLETE ADDRESS	
DATE	TELEPHONE
MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE	
INDIVIDUAL PRACTITIONER'S S.S. NUMBER	ALL OTHERS - EMPLOYER I.D. NUMBER

Policy Number: