



HOSPITAL INDEMNITY CLAIM FORM

INSTRUCTIONS:

- The Administrator will complete the Policyholder Statement section. You should complete all remaining sections and sign the Member Certification. **COMPLETION** of the entire form speeds claims processing.
- Please make sure that you sign the Authorization for Release of Information on the reverse side of this form.
- Have your provider of service complete the Physician or Supplier Information Section on the reverse side of this form.

MAIL COMPLETED FORM AND HOSPITAL BILL TO:
ACS MEMBER INSURANCE PROGRAM
1200 EAST GLEN AVE.
PEORIA HEIGHTS, IL 61616-5348
1-800-752-0179

CLAIM PROCESSING INFORMATION (COMPLETED BY MEMBER)

MEMBER'S LAST NAME: _____ FIRST NAME: _____ INITIAL: _____
 STREET ADDRESS: _____
 CITY: _____ STATE: _____ ZIP CODE: _____
 DAYTIME TELEPHONE NUMBER: _____
 () - _____

DATE OF BIRTH: MONTH ____ DAY ____ YEAR ____ SEX: MALE FEMALE
 MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED THROUGH ANY OTHER PLANS WHICH PROVIDE HOSPITAL INDEMNITY BENEFITS? YES NO
 IF YES, PROVIDE INFORMATION REQUESTED BELOW:
 OTHER CARRIER'S NAME _____
 ADDRESS: _____
 TELEPHONE NUMBER: _____
 NAME OF COVERED PERSON: _____
 PLAN NUMBER: _____

ON WHAT DATE DID SYMPTOMS FIRST APPEAR?
 MO ____ DY ____ YR ____

ON WHAT DATE DID THE PATIENT FIRST CONSULT OR RECEIVE MEDICAL TREATMENT FROM A PHYSICIAN FOR THIS ILLNESS OR ACCIDENT?
 MO ____ DY ____ YR ____

SOCIAL SECURITY NUMBER:

____ / ____ / _____

NAME AND ADDRESSES OF PHYSICIANS AND/OR MEDICAL FACILITIES TREATING THE PATIENT

NAME AND ADDRESS OF HOSPITAL WHERE CONFINED:

DATES OF HOSPITAL CONFINEMENT:

FROM _____ TO _____

FROM _____ TO _____

FROM _____ TO _____

NATURE OF SICKNESS OR INJURY:

PATIENT INFORMATION (COMPLETED BY MEMBER ONLY FOR DEPENDENT CLAIMS)

PATIENT LAST NAME: _____ FIRST NAME: _____ INITIAL: _____
 STREET ADDRESS (IF DIFFERENT FROM MEMBER'S ADDRESS): _____
 CITY: _____ STATE: _____ ZIP CODE: _____

PATIENT RELATIONSHIP TO MEMBER:
 SPOUSE CHILD STEPCHILD OTHER _____

PATIENT SEX: MALE FEMALE
 DATE OF BIRTH: MONTH ____ DAY ____ YEAR ____
 SOCIAL SECURITY NUMBER: ____ / ____ / _____

IF CLAIM IS FOR DEPENDENT CHILD, WHEN CHARGES WERE INCURRED, WAS CHILD:
 MARRIED? YES NO
 EMPLOYED? YES NO
 IN THE MILITARY? YES NO
 FEDERAL EMPLOYEE? YES NO

MEMBER CERTIFICATION (COMPLETED BY MEMBER)

PLEASE NOTE: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I CERTIFY THAT THE CLAIM PROCESSING AND PATIENT INFORMATION SHOWN ABOVE IS COMPLETE AND ACCURATE.

MEMBER'S SIGNATURE _____ DATE _____
 (SIGNATURE OF DEPENDENT SPOUSE IS NOT ACCEPTABLE)

POLICYHOLDER STATEMENT (COMPLETED BY ADMINISTRATOR)

MEMBER'S LAST NAME: _____ FIRST NAME: _____ INITIAL: _____
 SEX: MALE FEMALE DATE OF BIRTH
 MO ____ DY ____ YR ____

MEMBER'S INSURANCE EFFECTIVE DATE: MO ____ DY ____ YR ____

MEMBER'S PAID TO DATE: MO ____ DY ____ YR ____

CERTIFICATE HOLDER ID: _____

NAME OF POLICYHOLDER: _____

I HEREBY CERTIFY THAT THE ABOVE FACTS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

DATE SIGNED: _____ BY: _____

GROUP POLICY NUMBER: _____

CANCER/ICU BENEFIT YES NO

SURGICAL BENEFIT YES NO

AMOUNT OF DAILY BENEFIT: \$ _____
 (INDICATE APPLICABLE BENEFIT)
 \$1000 \$2000

DOES THIS MEMBER HAVE DEPENDENTS' INSURANCE? YES NO
 IF YES, SPOUSE CHILDREN

DEPENDENTS' INSURANCE EFFECTIVE DATE: MO ____ DY ____ YR ____
 (IF APPLICABLE)

AMOUNT OF DAILY BENEFIT (DEPENDENT) \$ _____

DEPENDENT'S PAID TO DATE: MO ____ DY ____ YR ____

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/GUARDIAN IF MINOR)

DATE

PHYSICIAN OR SUPPLIER INFORMATION (MUST BE COMPLETED IN FULL BY PROVIDER OF SERVICE)

DATE OF CURRENT:

MO DY YR
____/____/____

- ILLNESS (FIRST SYMPTOM) OR
 INJURY (ACCIDENT) OR
 PREGNANCY (LMP)

DATE FIRST CONSULTED YOU FOR

THIS CONDITION MO DAY Y R
____/____/____

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:

1. _____
2. _____
3. _____
4. _____

HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO

IF YES, GIVE FIRST DATE:

MO DY YR
____/____/____

HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

MO DY YR MO DY YR
FROM ____/____/____ THROUGH ____/____/____

NAME OF REFERRING PHYSICIAN

IS CONDITION DUE TO PREGNANCY?

YES NO

IF YES, GIVE APPROXIMATE DATE PREGNANCY COMMENCED.

MO DY YR
____/____/____

PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

FEDERAL TAX I.D. NUMBER

SSN

EIN

SIGNATURE OF PHYSICIAN OR SUPPLIER

INCLUDING DEGREES OR CREDENTIALS

SIGNED _____ DATE _____

PLEASE REMEMBER TO ATTACH YOUR HOSPITAL BILL TO THIS CLAIM FORM AND MAIL TO THE ADDRESS ON THE REVERSE SIDE OF THIS FORM.



IMPORTANT NOTICE

Whenever a claim form is given to an insured who lives in any of the states listed below, this "Important Notice" must be attached to the claim form.

FOR ALASKA RESIDENTS

"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be prosecuted under state law."

FOR ARIZONA RESIDENTS

"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 the payment of a loss is subject to criminal and civil penalties."

FOR ARKANSAS RESIDENTS

"Any person who knowingly presents a false or fraudulent claim for the 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."

FOR CALIFORNIA RESIDENTS

"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."

FOR COLORADO RESIDENTS

"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 claimant for the purpose of defrauding or attempting to defraud the 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."

FOR DELAWARE RESIDENTS

"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."

FOR DISTRICT OF COLUMBIA RESIDENTS

"WARNING: It is a crime 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."

FOR FLORIDA RESIDENTS

"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of third degree in Florida."

FOR HAWAII RESIDENTS

"For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both."

FOR IDAHO RESIDENTS

"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."

FOR INDIANA RESIDENTS

"A 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."

FOR KENTUCKY RESIDENTS

"Any person who knowingly, and 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."

FOR LOUISIANA RESIDENTS

"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."

FOR MAINE RESIDENTS

"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 or a denial of insurance benefits."

FOR MINNESOTA RESIDENTS

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

FOR NEW HAMPSHIRE RESIDENTS

"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."

FOR 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 in New Jersey."

FOR NEW MEXICO RESIDENTS

"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 civil fines and criminal penalties."

FOR 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."

FOR OHIO RESIDENTS

"Any person who, with intent to defraud or knowing that he or she 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."

FOR OKLAHOMA RESIDENTS

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."

FOR OREGON RESIDENTS

"Any person who knowingly and with intent to defraud any insurance company 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, may be guilty of insurance fraud and may be subject to prosecution for insurance fraud."

FOR PENNSYLVANIA 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 subjects such person to criminal and civil penalties."

FOR PUERTO RICO RESIDENTS

"Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with the fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years."

FOR TENNESSEE RESIDENTS

"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."

FOR TEXAS RESIDENTS

"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."

FOR VERMONT 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."

FOR VIRGINIA RESIDENTS

"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 or a denial of insurance benefits."