ADMINISTERED BY:
NABCO
NORTH AMERICAN BENEFITS COMPANY
Claims Department
PO Box 3056
Southeastern, PA 19398-3056
Phone: 800-346-7813 Fax: 610-995-0181

NOTE: Please read this before submitting a claim.

Instructions for filling out an Accident Benefit Claim form.

- The claim form must be completed and signed by the insured. Please indicate your Group name on the claim form.
- Your Accident Benefit plan requires that treatment must be sought within a specific time frame. Please refer to the Schedule of Benefits in your Certificate of Insurance for the "Initial Care and Treatment".
- Proof of loss timeline: refer to Certificate of Insurance for submission timeline.
- You are required to provide medical records documenting all treatment received from all treatment providers consulted within the timeframe beginning three months prior to your reported accident through present date. Lack of receipt of all medical records as noted above will result in a delay in the review of your claim.
- Please attach itemized bills to the claim form. Please provide a hospital bill; a balance due bill from the hospital is **not** sufficient. An itemized bill is a statement that indicates:
  1) The date(s) of treatment,
  2) The type(s) of service,
  3) The diagnosis,
  4) The medical provider's name and address,
  5) The individual charge for each expense.
- Return the completed claim form and itemized bills to:

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- Please indicate which bills have been paid by you. If you prefer to assign payments to the medical provider, please complete and sign the authorization at the bottom of the claim form.
- A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, group name, and date of accident.
- We suggest that you make photocopies of any correspondence sent to our office to keep for your own records.
- By furnishing forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

IMPORTANT:

Please take note: delays in the processing of your claim will occur if all of the following have not been provided to our company: the completed claim forms and the itemized bills from your medical provider.

PLEASE NOTE: Incomplete claim forms will result in a delay in the processing of your claim.

MAIL CLAIMS TO:
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ACCIDENT BENEFIT CLAIM FORM

TO BE COMPLETED BY THE INSURED:

Group Name: _____ Name of Insured: _____

Insured Date of birth: _____ Social Security number: _____

Address: _____
Street City State Zip Code

Telephone number: _____ Email address: _____

Patient's Name and Relationship (If other than Insured): _____

Patient's Date of birth: _____ ☐ Male ☐ Female

Last day actively at work: _____

Have you returned to work? ☐ Yes ☐ No If Yes, when did you return to work? _____

Date and time of accident: _____

Where did the accident occur? _____

Please describe the Injury sustained as a result of the accident: _____

_____

_____

Please describe, in detail, the specific circumstances surrounding the accident: _____

_____

_____

Was this a work related accident / injury: ☐ Yes ☐ No

Was a claim filed due to this accident / injury with your Workers' Compensation carrier: ☐ Yes ☐ No

Have you ever had this condition before: ☐ Yes ☐ No If yes, please indicate month, date, and year: ____/____/____

Please provide a brief description of the treatment provided: _____

_____

I hereby authorize Madison National Life Insurance Company, Inc., to pay bills in connection with this accident directly to the Hospital or Other Medical Provider as indicated below: I understand that I am financially responsible to the Hospital or Other Medical Provider for charges not covered by the policy

_____ _____
Signature of Insured Date

_____ _____
Hospital or Other Medical Provider Name Hospital or Other Medical Provider Name

_____ _____
Address / Telephone number Address / Telephone number

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Signature _____ **Date** _____

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Patient Authorization to Release Protected Medical Information

You are not required to sign the authorization but, if you do not, Madison National Life Insurance Company may not be able to evaluate or administer your claim(s). Please complete this form in detail to assist us in providing a timely review of your claim for benefits.

Name (print): _____ Date of Birth: _____ Telephone number: _____

I authorize the use and/or release of my protected medical and/or mental health information to Madison National Life Insurance Company for the purpose of determining insurance eligibility. I authorize the release of information from:

1) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
2) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
3) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
4) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____

To: **NABCO**
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This form serves as an authorization for Madison National Life Insurance Company to obtain information documenting medical treatment, including patient notes, treatment records, lab reports, physical therapy, diagnosis and prognosis from _____ through two years from the date of this form. This form is also intended to be used to obtain psychological testing and psychological / psychiatric treatment including patient notes and treatment records from _____ through two years from the date of this form.

Also this form provides Madison National Life Insurance Company and any benefit plan administrators, the authorization to obtain information from any pharmacy, other insurance or annuity company, any consumer reporting agency, financial institution or tax preparer, any governmental agency (example Social Security Administration or Public Retirement System), all former and/or current employers, educational facility/entity, vocational or rehabilitation organization, employer sponsored disability/retirement carrier, worker's compensation carrier, and or any other entity or institution that may have information needed by Madison National Life Insurance Company for the review of my claim for benefits.

I understand this information will be used for the sole purpose of evaluating and administering my claim for benefits. I understand that I may revoke this authorization at any time by requesting the revocation in writing and submitting it to Madison National Life Insurance Company and to the providers listed above. I understand if I revoke this authorization, Madison National Life Insurance Company may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). This authorization will remain valid for two full years from the date of my signature.

I understand that in the course of conducting its business, Madison National Life Insurance Company may release / redisclose this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for Madison National Life Insurance Company in connection with my claim(s).I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws. I am aware my medical information may be redisclosed when necessary as part of the review process performed by Madison National Life Insurance Company at any point during the review of my claim or during any appeals that may take place as explained above.

I understand that I have the right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is valid as the original. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my authorization, however I understand if I do not sign this authorization or if I alter its content in any way, Madison National Life Insurance Company may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to each of my health care providers. I understand that, by signing this form, I am confirming my authorization that my health care provider may disclose to Madison National Life Insurance Company the protected health information described in this form.

Signature _____ **Date** _____

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ATTENDING PHYSICIAN'S STATEMENT

Thorough completion of this form will assist our company in completing a timely review of your patient's claim. This form must be completed by a physician.

Name of patient:______________________________

Date of birth:______________________ Social Security Number:______________________

DIAGNOSIS

Primary diagnosis:______________________________ ICD-10 code:______________

Secondary diagnosis:______________________________ ICD-10 code:______________

Date patient became unable to work: ______________________

Date your patient can return to work: Part time ______________ Full time ______________

Unable to determine return to work, due to: ______________________________

This condition is the result of an ☐ Illness ☐ Accident If an accident; on what date did the accident occur: ______________

If an accident, how do you understand the accident occurred:______________________________

____

____

____

On what date were you first consulted for this condition:______________________________

If patient was hospitalized, please provide dates: Admitted______________ Discharged______________

Admitting diagnosis:______________________________

Discharge diagnosis:______________________________

Name of hospital:______________________________

Name of provider seen at hospital:______________________________

Address:______________________________
Street City State Zip Code

Was this patient referred from another physician ☐ No ☐ Yes If yes, please indicate the name and address of the referring physician:

____

Was surgery performed? ☐ No ☐ Yes If yes indicate procedure and date of surgery: ______________________

____

PLEASE READ CAREFULLY

MEDICAL RECORDS ARE REQUIRED IN ORDER FOR A PROPER REVIEW OF THIS CLAIM. WE ASK THAT YOU ATTACH COPIES OF LABORATORY DATA, RESULTS OF DIAGNOSTIC TESTS, OFFICE VISIT NOTES, PATIENT SURGICAL REPORTS, HOSPITALIZATION RECORDS, CHART NOTES AND NARRATIVE REPORTS FROM THREE MONTHS BEFORE DISABILITY THROUGH PRESENT DATE. LACK OF MEDICAL RECORDS WILL RESULT IN A DELAY IN THE REVIEW OF THIS CLAIM AND A DELAY IN POSSIBLE PAYMENT OF BENEFITS.

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Physician's signature:______________________________ **Date:**______________

Physician's name (please print):______________________________ Specialty:______________

Address:______________________ City:______________ State:__________ Zip Code:__________

Phone number:______________________ **Medical record department fax number:**______________

FRAUD WARNING: 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 may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, West Virginia, Wisconsin and Wyoming.

STATE SPECIFIC FRAUD WARNINGS

ALABAMA WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
ARIZONA WARNING: For your protection Arizona law requires the following statement to appear on the is form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
CALIFORNIA WARNING: 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.
COLORADO WARNING: 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 damage. 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 WARNING: Any person who knowingly and 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.
KENTUCKY WARNING: 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.
LOUISIANA WARNING: 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.
MAINE WARNING: 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.
MARYLAND WARNING: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
NEW HAMPSHIRE WARNING: 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 WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
NEW MEXICO WARNING: 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.
OHIO WARNING: 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.
PENNSYLVANIA WARNING: 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 WARNING: 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.
WASHINGTON WARNING: 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.