Washington National Insurance Company
Home Office: 11825 N. Pennsylvania St., Carmel, IN 46032

Questions about your claim submission?
CALL (800) 541-2254

# ACCIDENTAL INJURY CLAIM FORM

PLEASE SUBMIT THESE ITEMS WITH ALL CLAIMS:

- ☐ Accidental Injury claim form (CLM-FORM-ACC)—signed
- ☐ Authorization to obtain medical/confidential information (see attached form)—signed
- ☐ Itemized medical bills for treatment

Required:

- ☐ Patient information
- ☐ Date of service
- ☐ Charge amount
- ☐ CPT code or procedure description
- ☐ ICD code or diagnosis for treatment

*Please note: Medicare statements and Explanation of benefits (EOBs) from other insurance companies cannot be used to process claims.*

May include:

- ☐ *Automobile accident*—Police report
- ☐ *Surgery*—Operative report and surgeon bill(s) for completed procedures
- ☐ *Hospital and/or emergency room visit*—Admission and/or discharge paperwork and bill(s) for treatment (Examples: UB04, CMS 1500, etc.)
- ☐ Death certificate

Will you also be filing a disability claim? ☐ Yes ☐ No

*If yes, please complete the disability form (CLM-FORM-DI) available at WashingtonNational.com or by contacting (800) 541-2254.*

WHERE TO SUBMIT CLAIMS:

- ☐ *Mail:* Washington National Claims Department, P.O. Box 2024, Carmel, IN 46082-2024
- ☐ *Express mail:* Attn: Claim Processing 2024, 11825 N. Pennsylvania St., Carmel, IN 46032
- ☐ *Fax:* (888) 229-1414

## SECTION A: POLICYOWNER/CERTIFICATE HOLDER INFORMATION (please print)

| | | |
|---|---|---|
| Policy or certificate number | | |
| Last name | First name | Middle initial |
| Date of birth | Social Security number | |
| Mailing address ☐ Check box if this is a new permanent address ☐ Check box if address change applies to everyone on the policy | | |
| City | State | ZIP code |
| If mailing address is a P.O. Box, please indicate physical address here: | | |
| Work address | | Email |
| Home phone number | May we leave a voice mail here? ☐ Yes ☐ No | |
| Work phone number | May we leave a voice mail here? ☐ Yes ☐ No | |

## SECTION B: PATIENT ADDRESS INFORMATION (if different from Policyowner/Certificate holder)

| Last name | First name | Middle initial |
|---|---|---|
| Social Security number | Phone number | Date of birth |
| Mailing address | | |
| City | State | ZIP code |

## SECTION C: PATIENT INFORMATION

| Gender: | Marital status: | Relationship: |
|---|---|---|
| ☐ Male | ☐ Single | ☐ Self ☐ Spouse ☐ Dependent |
| ☐ Female | ☐ Married | ☐ Check if dependent is a full-time student *(Include documentation to confirm student status)* |
| | ☐ Other | ☐ Check if dependent is disabled |
| | | ☐ Check if insured is deceased; date deceased: ____/____/_____ |

| Place of employment | Occupation and Title | Work phone number |
|---|---|---|

## SECTION D: DESCRIPTION OF ACCIDENT

Please provide a thorough description of the accident.
Your policy document provides the definition of an accident for reference in completing this section.

1. Where did this event occur? ☐ On job ☐ Off job: indicate where: _____

2. Date of event ____/____/_____

3. Have you been treated for the same or similar condition *prior* to this occurrence? ☐ Yes ☐ No

4. Please describe the event that caused your injury. (attach additional pages, if needed)

_____

_____

_____

_____

5. Please describe the physical injury caused by the event. (attach additional pages, if needed)

_____

_____

_____

_____

## SECTION E: PHYSICIAN AND MEDICAL FACILITY INFORMATION

Physician or medical facility where treated

| Treating physician name | Phone number | Fax number |
|---|---|---|
| Address | | |
| City | State | ZIP code |
| Email | | |

| Primary physician name (if different than treating physician) | Phone number | Fax number |
|---|---|---|
| Address | | |
| City | State | ZIP code |
| Email | | |

| Hospital name (if applicable) | Phone number | Fax number |
|---|---|---|
| Address | | |
| City | State | ZIP code |
| Email | | |

| Rehabilitation unit name (if applicable) | Phone number | Fax number |
|---|---|---|
| Address | | |
| City | State | ZIP code |
| Email | | |

**Puerto Rico residents only:** Please provide the following information for your major medical insurer:

| Name of major medical insurer | Primary insured name |
|---|---|
| Address | |
| City / State / ZIP code | |
| Group number | Phone number |

## SECTION F: PATIENT AND POLICYOWNER/CERTIFICATE HOLDER SIGNATURE SECTION

Please be sure to include the following information with this claim form:

☐ Itemized bills from a physician and/or facility including diagnosis and/or procedure codes and charge amounts
(Itemized bills may include but are not limited to the following claim forms: UB04, CMS 1500, etc.)

By signing my name on this document, I declare that all of the information given is true and correct to the best of my knowledge and belief. I acknowledge I have received all required fraud warnings at the time of signing this form.

_____ _____ _____/_____/_____

Patient signature (or legal representative) | Relationship to Policyowner/Certificate holder

_____ _____/_____/_____

Policyowner or Certificate holder signature (or legal representative) | Date

## SECTION G: PHYSCIAN STATEMENT

### To be completed and signed by the physician

*Please answer each question COMPLETELY. Failure to complete all sections may delay processing of this claim.*

| Policy or certificate number | Policyowner or Certificate holder name | |
|---|---|---|
| Patient name | Patient date of birth | |
| Physician name | Phone number | Fax number |
| Mailing address | | |
| City | State | ZIP code |
| Physician email | | |

Where did this event occur? ☐ Home ☐ Work ☐ Other: _____ Date of event: ____/____/_____

Please describe how this event occurred.

To your knowledge, has this patient ever had the same or a similar medical condition? ☐ Yes ☐ No
If yes, please describe (including date):

| Date of service | Diagnosis/ICD code | Surgery/CPT code | Description of surgery | Charges |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Was patient hospitalized as result of the diagnosis? ☐ Yes ☐ No ➤<br>If yes, was patient kept overnight? ☐ Yes ☐ No | Confinement dates | Discharge date |
|---|---|---|
| Hospital name | City | State |

| Was patient confined to the ICU? ☐ Yes ☐ No ➤<br>Level of care provided _____ | Confinement dates |
|---|---|

Is patient's past medical history on file in your office? ☐ Yes ☐ No; If yes, years available: _____

_____ ____/____/_____ _____

Physician signature Date Tax ID number

# FRAUD WARNING NOTICES
## PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

**NOTICE:** Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

**ALABAMA:** 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.

**ALASKA, DELAWARE, FLORIDA, IDAHO:** Your state requires us to notify you that: 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 as further defined by your state statute.

**ARKANSAS, HAWAII, LOUISIANA, MAINE, NEW MEXICO, RHODE ISLAND, TENNESSEE, TEXAS, VIRGINIA, WEST VIRGINIA:** 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.

**ARIZONA, KENTUCKY, 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.

**CALIFORNIA:** For your protection California law requires the following warning statement 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: any person who knowingly and with intent to defraud an insurer provides false, incomplete or misleading information is subject to criminal and civil penalties, including imprisonment, fines and denial of insurance. Any agent who knowingly and with intent to defraud a policyholder or claimant provides false, incomplete or misleading information with regard to a settlement or insurance proceeds payable will be reported to the Colorado Insurance Department.

**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.

**INDIANA, MINNESOTA:** Your state requires us to notify you that: any 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.

**MARYLAND:** Any person who knowingly and 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:** Your state requires us to notify you that any person, 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 under New Hampshire law.

**NEW JERSEY, PENNSYLVANIA:** NOTICE: 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.

**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.

**PUERTO RICO:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**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.

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# Authorization to obtain medical/confidential information

Conforms to HIPAA Privacy Rule

## 1. My information—the individual who is the subject of the information

| Printed name | Date of birth | Social Security number | |
|---|---|---|---|
| Address | City | State | Zip |

## 2. Disclosing party—parties authorized to release information about me

Any physician or other healthcare provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy-related organization, insurance company or health plan, Social Security Administration, governmental agency or my employer

## 3. Description of my information authorized for release

- Any information related to my past, present or future health condition(s), medical care/treatment or prescription drug history, which includes information about mental health (excluding psychotherapy notes), communicable disease, HIV/AIDS, alcohol and substance abuse; and
- Any information regarding my past, present or future employment that is reasonably necessary to process and administer my claim(s) for accident insurance and/or disability income insurance benefits.

## 4. Purpose of authorization—how my information will be used

To administer benefits under a policy or certificate of insurance.

## 5. Duration of authorization

Twenty-four (24) months from the date written below, unless I specify an earlier date here: _____

## 6. Receiving parties—parties authorized to receive information about me

CNO Services, LLC on behalf of one or more of the following insurance companies: Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company*, Colonial Penn Life Insurance Company, Conseco Life Insurance Company, Conseco Life Insurance Company of Texas, Washington National Insurance Company, Primerica Life Insurance Company, Jefferson National Life Insurance Company

*domiciled in and licensed in the State of New York

## 7. Important information—review carefully before signing

- Refusing to sign this authorization does not affect my ability to obtain medical treatment, but may prevent my insurance company from being able to determine if benefits are payable under the terms of my coverage.
- This authorization may be revoked at any time unless it was already relied upon. Send a written revocation to: Customer Service P.O. Box 2024, Carmel, IN 46082-2024.
- The receiving parties named above are subject to federal privacy laws. However, if I authorize parties who are not subject to these laws to receive medical information about me, then such information could be re-disclosed and would no longer be protected.
- I understand that I have a right to a copy of this authorization, and that a photocopy or facsimile is as valid as the original.
- California residents are entitled to a large print version of this form by calling (800) 541-2254 to request form HEALTHMEDAUTH-LARGE.

## 8. Approval—must be signed and dated by me or my legal representative* to be valid

Print name: _____ Relationship:_____

Signature: _____ Date: _____

* Legal representatives provide documentation of legal authority

Claims Department, P.O. Box 2024, Carmel, IN 46082-2024
Phone: (800) 541-2254 Fax: (317) 208-8656