UnitedHealthcare®

Claim Forms and Instructions
for
GROUP HOSPITAL INDEMNITY INSURANCE

EMPLOYER

EMPLOYER – *Form Completion Information*:

NOTICE OF CLAIM – Instructions

1. COMPLETE

- Employer's Report of Claim *(page 2)*

2. INCLUDE

- Copy of enrollment card (if employee contributes to premium)
- Copy of approved medical evidence of insurability if required at time of enrollment

3. TRANSMIT completed forms and attachments to:

UNITEDHEALTHCARE SPECIALTY BENEFITS
PO Box 7466
Portland, ME 04112-7466
Tel 800 539 0038 Fax 888 505 8550

4. PROVIDE employee with the accompanying Instructions and Claim Forms *(pages 3-5)*

- Instructions *(page 3)*
- Employee's Hospital Indemnity Insurance Statement *(page 4)*
- Disclosure Authorization *(page 5)*
- Authorization of Personal Representative *(page 6)*
- Attending Physician's Statement *(page 7)* If there is more than one treating physician, an additional claim form should be provided for each.

ALL PORTIONS OF THIS CLAIM FORM PACKAGE MUST BE COMPLETED TO AVOID UNDUE DELAY IN PROCESSING EMPLOYEE'S REQUEST FOR BENEFITS

1. Employee's Name:	2. Social Security Number:	3. Date of Birth:
4. Address: City: State: Zip Code:		

5. Location/Division:	6. Insurance Class:	7. Employee Date of Hire:	8. Effective Date of Coverage:	9. Last Day Worked:

10. Employee Contribution to premium: ☐ Yes* ☐ No *If EE paid please provide enrollment card	11. If Yes: ☐ Pre-tax ☐ Post-tax	12. If Post-tax*: _____ % paid by employer _____ % paid by employee *If this section is blank, we will assume it is 100% employer contributions and calculate FICA taxes accordingly. Please refer to IRS Publication 15A.

13. Employee's Occupation:	14. Employee's Work Status: ☐ Full-Time ☐ Part-Time ☐ Exempt ☐ Non-Exempt ☐ Seasonal ☐ Temporary

15. Regular scheduled hours per week:	16. Check off Regular work days: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

17. Flat Benefit Amount $ _____	18. Salary Period (check one): ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly Premium Per Pay Period :_____

Claimant Name (if not the Employee):	Date of Birth:	Social Security Number:
Employer's Name (name of policyholder, if other):		Policy Number:
Address City State Zip Code		
Telephone Number (include area code):	Fax Number (include area code):	
Name of person completing this form (please type or print)	Title	
Signature		Date

Please provide this completed claim form to the Insured Employee or submit to:

UNITEDHEALTHCARE SPECIALTY BENEFITS
PO Box 7466
Portland, ME 04112-7466
Tel 800 539 0038 Fax 888 505 8550

Please be sure to include the enrollment forms if the employee contributed to the premiums for this coverage. We will obtain the enrollment forms upon receipt of this claim. However, please understand that this may delay the claim process.

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GROUP HOSPITAL INDEMNITY INSURANCE

EMPLOYEE

EMPLOYEE – *Form Completion Information*:

APPLICATION for Group Hospital Indemnity Insurance Instructions

1. **COMPLETE** Employee's Hospital Indemnity Insurance Statement *(page 4)* in FULL.

2. **COMPLETE** Disclosure Authorization *(page 5)*. This will allow us to secure additional information, if necessary, to make a decision on your claim for benefits. Make a copy to provide to your treating physician(s).

3. **COMPLETE** Authorization of Personal Representative *(page 6)*. This form is optional and **not** required to file a claim. If you would like us to discuss your claim with anyone, we require your authorization prior to us releasing any personally identifiable health information.

4. **TRANSMIT** completed forms and attachments to:

   UNITEDHEALTHCARE SPECIALTY BENEFITS
   PO Box 7466
   Portland, ME 04112-7466
   Tel 800 539 0038 Fax 888 505 8550

5. **PROVIDE** the Attending Physician's Statement *(page 7)* to the physician (s) treating you. If you have more than one physician, you may make copies or obtain additional Attending Physician's Statements from your employer.

6. **PROVIDE** a copy of your completed Disclosure Authorization to your physician(s).

7. **INSTRUCT** your physician(s) to respond to any requests for information from us by sending requested records to:

   UNITEDHEALTHCARE SPECIALTY BENEFITS
   PO Box 7466
   Portland, ME 04112-7466
   Tel 800 539 0038 Fax 888 505 8550

ALL PORTIONS OF THIS CLAIM FORM PACKAGE MUST BE COMPLETED TO AVOID UNDUE DELAY IN PROCESSING YOUR REQUEST FOR BENEFITS

EMPLOYEE'S HOSPITAL INDEMNITY INSURANCE STATEMENT

TO BE COMPLETED BY EMPLOYEE

INFORMATION ABOUT THE COVERED EMPLOYEE			
1. Full Name (First, Last, Middle Initial):	2. Gender: ☐ M ☐ F	3. Social Security Number:	4. Date of Birth:
5. Address:	City:	State:	Zip Code:
6. Home Telephone:	7. Alternate Telephone:		

INFORMATION ABOUT THE CLAIMANT			
8. Claimant's Name:	9. Gender ☐ M ☐ F	10. Social Security Number:	11. Date of Birth:
12. Mailing Address (Street or PO Box):	City:	State:	Zip Code:
13. Home Telephone:	14. Alternate Telephone:	15. Dates of Confinement That You Are Claiming:	

INFORMATION ABOUT THE HOSPITAL/FACILITY/PHYSICIAN		
16. Name of Hospital or Facility:	17. Address of Hospital or Facility:	18. Telephone Number:
19. Name of Admitting/Treating Physician	20. Address (if different than above):	21. Telephone Number (if different than above):

CLAIMANT OR BENEFICIARY SIGNATURE (if under 18, signature of parent or guardian is required)

The above statements are true and complete to the best of my knowledge and belief.

I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.

Printed Name: _____

Parent or Guardian Name (if applicable, please print): _____

Signature: _____

Date: _____/_____/_____

The benefits that you may be eligible to receive under this policy will be determined by the billing records, complete with revenue codes, provided by the hospital or facility where you received treatment. To help expedite your claim, please provide a copy of the billing records provided by the hospital or facility where you received treatment. If you do not have a copy of the billing records we will obtain a copy direct from the hospital or facility at no cost to you. However, please understand that this may delay the claim process.

Participant's Name (Please Print):_____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, pharmacy benefit manager, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give UnitedHealthcare Insurance Company (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and non-medical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my Plan Administrator sponsors both a disability plan underwritten or administered by the Company and a medical plan of any type written by another UnitedHealth Group Company, the information and records described in this form may also be given to any UnitedHealth Group Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, benefit plan administrator, or governmental agency, including the Social Security Administration, to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claims files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT: (a) reinsuring companies; (b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); (c) fraud or overinsurance detection bureaus; (d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; (e) for audit or statistical purposes; (f) as may be required or permitted by law; or (g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drugs or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, I understand that if I do so, the Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or
Claimant's Authorized Representative:_____ Date: _____

Relationship, if other than Claimant: _____

RETURN TO:
UnitedHealthcare Specialty Benefits
PO Box 7466 Portland ME 04112-7466
Tel 800 539 0038 Fax 888 505 8550

At my request, and for my convenience, I, _____ hereby authorize **UnitedHealthcare Insurance Company** and any representatives thereof involved in the administration of my hospital indemnity insurance claim to recognize _____ as my Authorized Personal Representative in relation to such claim.

In connection therewith, I understand that _____ may be given access to information concerning my claim, including personally identifiable health information, and hereby authorize the disclosure of such information to said person when requested or as may be necessary to carry out the purpose of this Authorization. I direct that **UnitedHealthcare Insurance Company** not require any further authentication of the identity of my Authorized Personal Representative beyond the identification of his/her name in writing or orally at the time of any communication.

I further understand that any information provided to my authorized personal representative hereunder may be subject to further disclosure by said person, and I agree to hold **UnitedHealthcare Insurance Company** and its representatives harmless in connection with any such disclosure.

This Authorization shall remain valid so long as my claim shall remain open, but I understand that it may be revoked in writing by me at any time.

Date: ____/____/_____

Signature: _____

RETURN TO:
UnitedHealthcare Specialty Benefits
PO Box 7466 Portland ME 04112-7466
Tel 800 539 0038 Fax 888 505 8550

HOSPITAL INDEMNITY INSURANCE CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED BY PHYSICIAN

PO Box 7466, Portland, ME 04112-7466
Tel: 800 539 0038 Fax 888.505.8550

PATIENT INFORMATION		
Full Name (First, Last, Middle Initial):	Social Security Number:	Date of Birth:

ATTENDTING PHYSICIAN'S STATEMENT (to be completed by Physician)		
Nature of Sickness of Injury:		
ICD10 Code:	Date Admitted: _____ Date Discharged: _____	
Name of Hospital or Facility:	Address of Hospital or Facility:	Telephone Number:
Name of Admitting/Treating Physician	Address (if different than above):	Telephone Number (if different than above):

ATTENDTING PHYSICIAN'S SIGNATURE
I hereby certify that the above described information is based upon reasonable medical probability and Is true and correct to the best of my knowledge and belief. **I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.**

Signature: _____

Medical ID #: _____

Date: _____/_____/_____

FRAUD WARNING NOTICES: (Please review notice that applies in your state

For claimants in 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.

For claimants in Alaska:

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

For claimants in Arizona:

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

For claimants in California:

UnitedHealthcare may terminate your coverage and/or deny any claim under the policy if it is determined that you: knowingly, and with actual intent to deceive, presented false information in this application; and such statement was the basis for UnitedHealthcare's approval of your coverage under the policy.

For claimants in Colorado:

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 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.

For claimants in Connecticut:

Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For claimants in Delaware:

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 claimants in 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.

For claimants in Florida:

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

For claimants in Hawaii:

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 claimants in Idaho:

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 claimants in Indiana:

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 claimants in Kansas:

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 may be guilty of fraud as determined by a court of law.

For claimants in Kentucky:

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 claimants in Maine:

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.

For claimants in Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For claimants in Minnesota:

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

For claimants in New Hampshire:

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 claimants in New Jersey:

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

For claimants in New Mexico:

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 penalties.

For claimants in Ohio:

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.

For claimants in Oklahoma:

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive and insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For claimants in Oregon:

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 may be subject to fines and confinement in prison.

For claimants in Pennsylvania:

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 claimants in Tennessee and 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.

For claimants in Texas:

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 claimants in Vermont:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For claimants in Virginia:

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 false, incomplete, or misleading information may have violated state law.

For claimants in All Other States:

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.