**Colorado Bankers Life Insurance Company®**
Attn: Claims Department
2327 Englert Drive
Durham NC 27713
1.800.367.7814 © Fax: 1.855.777.5433
Email: Claims@CBLife.com © CBLife.com

# CLAIM FORM FOR PAYCHECK PROTECTION PLUS® (ACCIDENT DISABILITY INSURANCE)

The claimant is to complete the statement on this page and sign the second page of the form. The physician should complete the statement on the second page. Submit itemized bills.

## CLAIMANT'S STATEMENT

POLICY NUMBER: _____

| | | | | | |
|---|---|---|---|---|---|
| Insured Info | 1. | Insured name: | | DOB: | SSN: |
| | | Address: | City: | State: | Zip: |
| | | | | Phone: | |
| | | Email address: | | | |
| Patient Info | 2. | Patient name: | | Patient's DOB: | |
| | | Relationship to Insured: ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other | | | |
| Accident Info | 3. | Did the patient have an injury due to an accident? ☐ yes ☐ no | | | |
| | | Date of accident: | Time: | Date work stopped: | Time: |
| | | Where did the accident occur? | | | |
| | | Describe accident: | | | |
| | | Describe injuries in detail: | | | |
| | | Has the patient had a similar injury within the past 2 years? ☐ yes ☐ no | | | |
| | 4. | Date of first medical treatment: | | Time: | |
| | | Name and address of physician: | | | |
| | | Was the patient confined to a hospital for at least 24 hours? ☐ yes ☐ no | | | |
| | | If yes, provide name and address of hospital: | | | |
| | | Admission date: | | Discharge date: | |
| Patient Work Info | 5. | Did this claim happen on the job? ☐ yes ☐ no | | | |
| | | Patient's employer: | | Current occupation: | |
| | | Address of employer: | | | |
| | | Employer's phone #: | | Job duties: | |
| | 6. | Total disability from usual occupation from: | | to: | |
| Employer's Work/ Loss Statement | | **The following section must be completed by the employer for all disability claims:** | | | |
| | 7. | Date of employee's last day worked: | | Date employee returned to work: | |
| | 8. | Will you provide "light duty" if employee is released with restrictions? ☐ yes ☐ no | | | |
| | | List specific light duties assigned, if applicable: | | | |
| | 9. | Name (please print): | | Title: | Date: |
| | | Authorized signature: | | **Authorized contact phone number (required):** | |
| Motor Vehicle | 10. | If injury was due to a motor vehicle accident, send a copy of the police report. | | | |

**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 information concerning material thereto, commits a fraudulent insurance act that may subject such person to criminal and civil penalties (not enforceable in Oregon, Virginia, New Jersey and Florida).

**SIGN AND DATE THE SECOND PAGE OF THIS FORM; COMPLETE IN FULL OR FORM WILL BE RETURNED.**

I hereby authorize any physician, medical practitioner, hospital, clinic, Health Maintenance Organization, including Mayo, Kaiser Foundation, Veterans Administration, or other medical or medically related facility, insurance company, or other person, organization or institution, that has any record or knowledge of me or my dependents, to give Colorado Bankers Life Insurance Company or its reinsurer any records or knowledge of my health, medical history or physical condition, including psychiatric histories, to sue for claims investigative purposes and further, to testify as to such information. This authorization is valid for thirty (30) months after the date it was signed. A photo copy of this authorization will be as valid as the original, and I or my representative can obtain a copy on request.

Insured's signature: _____ Date: _____

Patient's signature: _____ Date: _____

## ATTENDING PHYSICIAN'S STATEMENT

Must be completed by Physician

<table>
<tr><td>1.</td><td colspan="2">Diagnosis:</td></tr>
<tr><td>2.</td><td colspan="2">Is the patient's condition the result of an accidental injury? ☐ yes ☐ no</td></tr>
<tr><td>3.</td><td colspan="2">Is condition due to injury arising out of patent's employment? ☐ yes ☐ no</td></tr>
<tr><td>4.</td><td colspan="2">Report of Services (Attach Itemized Bill)
<table>
<tr><th>Date of Services</th><th>Place of Services</th><th>Description of Surgical or Medical Services Rendered</th><th>Procedure Code (if used)</th></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>5.</td><td colspan="2">Date symptoms first appeared or accident happened?</td></tr>
<tr><td>6.</td><td colspan="2">Date patient first consulted you for this condition:<br>If patient was referred to you, provide name and address of referring physician:</td></tr>
<tr><td>7.</td><td colspan="2">Has patient ever had same or similar condition? ☐ yes ☐ no If so, when?</td></tr>
<tr><td>8.</td><td colspan="2">Is patient still under your care for this condition? ☐ yes ☐ no If no, when was last treatment date?</td></tr>
<tr><td rowspan="2">9.</td><td>a. Patient was continuously totally disabled (unable to work) from:</td><td>to:</td></tr>
<tr><td colspan="2">b. For any occupation? ☐ yes ☐ no</td></tr>
<tr><td rowspan="3">10.</td><td>a. Patient was partially disabled from:</td><td>to:</td></tr>
<tr><td colspan="2">b. For any occupation? ☐ yes ☐ no</td></tr>
<tr><td colspan="2">c. For his/her regular occupation? ☐ yes ☐ no</td></tr>
<tr><td>11.</td><td colspan="2">Is there any other information regarding the patient's health that we should be aware of?</td></tr>
</table>

Physician's signature: _____ Date: _____

Print name: _____

Address: _____

_____

_____ Phone: _____

# FRAUD WARNING NOTICE

The laws of some states require us to furnish you with the following notice:

**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.

**Arkansas, Louisiana, Massachusetts, Rhode Island** – 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.

**Colorado** – It is unlawful to knowingly provide false, incomplete, or misleading material 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 material 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** – 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.

**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.

**Kentucky** – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

**Maine, Tennessee, Virginia, 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.

**Maryland** – Any person who knowingly or willfully presents a false or fraudulent claim for payment of 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.

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

**New Jersey** – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**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 criminal penalties.

**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.

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

**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.

**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.

**All Other States** – Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.