SURETY LIFE AND CASUALTY INSURANCE COMPANY

827 28TH St. S Unit C FARGO ND 58103

FOR OFFICE USE-
CLAIM NUMBER: _____

CLAIMANT'S STATEMENT

PLEASE PRINT – DO NOT WRITE

CLAIMANT'S FULL NAME (MR.) (MISS) (MRS)

HOME PHONE ( ) _____ - _____
CELL PHONE ( ) _____ - _____
BUSINESS PHONE ( ) _____ - _____

ADDRESS (Street and No.) (City) (State) (Zip)

POLICY / FORM NUMBER (S)

BIRTH DATE / /

CLAIMANTS SOCIAL SECURITY # _____ / _____ / _____

OCCUPATION

ARE YOU ALSO FILING A CLAIM UNDER WORKER'S COMP ACT?
☐ YES ☐ NO

EMPLOYER'S NAME

PHONE NUMBER ( ) _____ - _____

EMPLOYER'S ADDRESS

IF YOU HAVE OTHER ACCIDENT, SICKNESS OR HOSPITAL INSURANCE, GIVE COMPANY NAME

IF CLAIM IS FOR ----------->>>>> **SICKNESS** PLEASE COMPLETE ---------->>>>>

DATE OF FIRST SYMPTOMS

_____ / _____ / 20_____

HAVE YOU EVER HAD SAME OR SIMILAR CONDITION?

☐ YES ☐ NO IF YES, GIVE DATE _____ / _____ / _____

NATURE OF SICKNESS

IF CLAIM IS FOR ----------->>>>>> **ACCIDENT** PLEASE COMPLETE ---------->>>>>

DATE OF ACCIDENT _____ / _____ / 20____

TIME OF ACCIDENT _____AM _____PM

NATURE OF INJURIES

PLEASE STATE HOW ACCIDENT OCCURRED, WHERE YOU WERE AND WHAT YOU WERE DOING AT THE TIME OF ACCIDENT.

PLEASE COMPLETE FOR BOTH **ACCIDENT AND SICKNESS** CLAIMS

HOSPITAL'S NAME AND ADDRESS AND CONFINEMENT DATES

_____ FROM_____ TO_____

ATTENDING PHYSICIANS' NAMES AND ADDRESSES — DATES OF TREATMENT

_____ _____

_____ _____

_____ _____

A) TOTAL DISABILITY: BETWEEN WHAT DATES WERE YOU UNABLE TO PERFORM ANY DUTIES? A) FROM _____ / _____ / 20____ THROUGH _____ / _____ / 20____

B) DATE RETURNED TO WORK B) FROM _____ / _____ / 20____ THROUGH _____ / _____ / 20____

I REPRESENT THE ABOVE INFORMATION TO BE TRUE TO THE BEST OF MY BELIEF. **FRAUD 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.**

I authorize any hospital, medical practitioner, medically related facility, insurance company, employer or consumer-reporting agency to release to Surety Life and Casualty Insurance Company any information concerning my health for the purpose of processing a claim. Surety is also authorized to disclose such information to any doctor. This authorization or photocopy shall be valid for the duration of the claim. A copy is available upon request.

DATE _____ / _____ / _____ **SIGNED:** _____
CLAIMANT'S SIGNATURE
(If Minor, Parents Signature / If Legal Representative please provide proof)

EMPLOYER'S STATEMENT

Employees Name	Worker's Comp Claim filed for this disability? ☐ YES ☐ NO	Name & address of compensation carrier

TOTAL DISABILITY: Between what dates did Employee give up all duties? From_____ / _____ / _____ To_____ / _____ / _____

Date returned to work _____ / _____ / _____

Signature & Title _____ Date _____ / _____ / _____ Telephone ( ) _____ - _____

Fraud Notice: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name Address City State Zip Code Date of Birth

1. NATURE AND ORIGIN OF: ☐ SICKNESS ☐ INJURY **Confirmed by X-RAY?** ☐ YES ☐ NO

DIAGNOSIS (Describe complications, if any)

2. WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN? DATE _____ / _____ / _____

3. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE _____ / _____ / _____

4. HOW DID CONDITION ORIGINATE?

5. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO

IF "YES", STATE WHEN AND DESCRIBE

6. DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION.

7. NATURE OF SURGICAL PROCEDURE, IF ANY. (DESCRIBE FULLY & GIVE APPROACH USED IF MORE THAN ONE IS POSSIBLE)

DATES_____ APPROACH USED_____

CLOSED REDUCTION?_____ OPEN REDUCTION?_____ METAL FIXATION?_____

8. GIVE DATES OF TREATMENT AND NATURE OF TREATMENT OTHER THAN SURGICAL.

DATES	NATURE OF TREATMENT
OFFICE	
HOME	
HOSPITAL	

9. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

IF DISCHARGED, GIVE DATE & DEGREE OF RECOVERY. DATE_____ **RECOVERED?** ☐ YES ☐ NO

10. IF PATIENT HOSPITALIZED, GIVE HOSPITAL DATES FROM _____ / _____ / _____ TO_____ / _____ / _____

HOSPITAL NAME & ADDRESS, CITY & STATE _____

11. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?

FROM _____ / _____ / _____ THROUGH _____ / _____ / _____

PHYSICIAN'S SIGNATURE_____ DEGREE_____

COMPLETE ADDRESS_____PHONE_____DATE_____

MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE

INDIVIDUAL PRACTITIONERS S.S. NO.	ALL OTHERS – EMPLOYER I.D. NO.
_____-_____-_____	_____-_____

INSTRUCTIONS FOR FILING AN ACCIDENT CLAIM*

***IF YOU ARE FILING A CLAIM IN RELATION TO AN AMP**
(ACCIDENT WITH CRITICAL ILLNESS POLICY)
YOU MUST USE THE AMP CLAIM FORM TO SUBMIT YOUR CLAIM.

Claimant's Statement: Insured/Claimant should personally complete the Claimant's Statement.

Physician Statement: Have your doctor complete a Physician's Statement.

Employer's Statement: Have your employer complete the Employer's Statement.

Claim related billing: Submit claim related billing. Contact the Business Office of each hospital and/or Physician (Clinic), in which services were rendered in relation to your claim. Request and forward the following billing forms to Surety Life and Casualty -

- **Hospital/ER charges should be submitted on a CMS-1450/UB-04 Claim Form**
- **Clinical/Physician charges should be submitted on a CMS-1500 Claim Form**
- **Please also submit ambulance charges if applicable to your claim.**

Upon completion, please mail your completed claim information to Surety Life and Casualty 827 28th St. S Suite C; Fargo, ND 58103.

We will promptly proceed with the claims processing upon receipt of all information. Please be aware that Surety Life is not liable for fees incurred in relation to the completion of physician's Statements or for medical records needed to process a claim. We will notify you in the event additional information is needed in your case.

We are sorry for the unfortunate circumstances making your claim form necessary, but look forward to being of assistance to you any way we can. If you have any questions please contact the Claims Department locally at 701-235-6653, ext. 223 or toll-free by dialing 1-800-232-3979, ext. 223.