

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? <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER'S NAME		EMPLOYER'S ADDRESS
PHONE NUMBER () _____ - _____		
IF YOU HAVE OTHER ACCIDENT, SICKNESS OR HOSPITAL INSURANCE, GIVE COMPANY NAME		
IF CLAIM IS FOR ----->>>>> <u>SICKNESS</u> PLEASE COMPLETE ----->>>>>	DATE OF FIRST SYMPTOMS ____ / ____ / 20____	HAVE YOU EVER HAD SAME OR SIMILAR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE ____ / ____ / ____
	NATURE OF SICKNESS	
IF CLAIM IS FOR ----->>>>> <u>ACCIDENT</u> 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 <u>ACCIDENT AND SICKNESS</u> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Name & address of compensation carrier
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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
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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.

<u>DATES</u>	<u>NATURE OF TREATMENT</u>
<u>OFFICE</u>	
<u>HOME</u>	
<u>HOSPITAL</u>	

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. _____ - _____ - _____
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INSTRUCTIONS FOR FILING A CANCER 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's Statement: Have your doctor complete a Physician's Statement.

Pathology/Lab Reports: Submit a copy of all claim related Pathology/Lab Reports. You may obtain this information from your doctor's office.

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- (CMS-1450/UB-04 Claim Form for hospital charges and CMS-1500 Claim Form for clinical or physician charges).

Please keep in mind that Surety Life is not liable for fees that may incur in relation to the completion of Physician's Statements or for records, which are needed to process a claim.

Upon completion, please mail your 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 requested information.

If you have any questions please call the Claims Department locally at 701-235-6653, ext. 223 or toll-free by dialing 1-800-232-3979, ext. 223.