

PLEASE COMPLETE IN FULL AND RETURN WITHIN 30 DAYS.



The Order of United Commercial Travelers of America • A Fraternal Benefit Society
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
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FOR OFFICE USE ONLY: ADHIP HIP EMERGICARE SIP MAC

Universal Claim Application PLEASE PRINT

For Accident Medical Expense Insurance (AME) please submit all Explanation of Benefits from your insurance carrier(s) with this claim form.

POLICYOWNER INFORMATION (COMPLETE ALL QUESTIONS) Today's Date (MM/DD/YYYY): ____/____/____

1. Name: _____ Policy Number: _____
First, MI, Last
2. Address: _____
Street City State/Prov. Postal Code
Email Address: _____
3. Date of Birth: ____/____/____ 4. Sex: Male Female 5. Phone: (____) _____
Month/Day/Year

PATIENT INFORMATION

6. Name: _____ 7. Sex: Male Female
First, MI, Last name of patient
8. Relationship to Policyowner: Self Spouse Dependent 9. Date of Birth: ____/____/____
Month/Day/Year
10. Cause of Condition: Accident Illness
11. Date of Incident: ____/____/____ 12. Date First Treated: ____/____/____
Month/Day/Year Month/Day/Year
13. Describe how accident happened: _____

14. Area and extent of bodily injury/or illness: _____

15. Name(s) of Physician: _____
16. Address: _____
Street City State/Prov. Postal Code

HOSPITALIZATION (PLEASE ENCLOSE BILL OR CONFIRMATION OF CONFINEMENT)

17. Were you Hospitalized? Yes No From ____/____/____ To ____/____/____
Month/Day/Year Month/Day/Year
18. Were you in Intensive Care? Yes No From ____/____/____ To ____/____/____
Month/Day/Year Month/Day/Year
19. Name of Hospital: _____
20. Address: _____
Street City State/Prov. Postal Code

COMMENTS: _____

In Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
In Other States: 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.

ANY COST FOR COMPLETION OF THIS FORM IS THE RESPONSIBILITY OF THE PATIENT

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I authorize any physician, medical practitioner, hospital, clinic other medical or medically related facility, insurance or reinsuring company, consumer reporting agency or employer, having information available as to diagnosis, treatment and prognosis with respect to my physical or mental condition and/or treatment and any other non-medical information, to give The Order of United Commercial Travelers of America or its legal representative, any and all such information.

I understand the information obtained by use of the authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request to receive a copy of this authorization.

I agree that a photographic copy of this authorization shall be as valid as the original.

I understand that I am not required to sign this authorization form and that UCT will not condition the provision of payment for benefits to me on the signing of this authorization. However, UCT may condition payment of a claim for benefits on my authorization for disclosure of my information held by another person or entity, if such information is necessary to determine payment of a claim.

I agree that this authorization shall be valid for one year from the date shown below.

Release of all treatment records from: _____ to: _____

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

As described in the *Notice of Privacy Practices* of UCT. I understand that I may revoke this authorization in writing at anytime, except to the extent that action has already been taken by UCT in reliance on this authorization, by sending a written revocation to UCT, Privacy Officer, 1801 Watermark Drive, Suite 100, Columbus, OH 43215.

Name of Insured: _____ Social Security No.: _____ Date of Birth: _____

Date: ____/____/____ Signature: **X** _____
Month/Day/Year (Signature of Claimant or Representative)

If signed by a guardian or a power of attorney, we must have notarized papers verifying this.

ATTENDING PHYSICIAN'S STATEMENT (TO BE COMPLETED BY YOUR DOCTOR)

1. Patient's Name: _____ 2. Date of Birth: ____/____/____
Month/Day/Year

3. Diagnosis: _____

4. History of condition provided by patient: _____

5. Accident?: Yes No Date: ____/____/____
Month/Day/Year

6. List all dates of treatment for this condition during the past two years: _____

7. If Hospitalized: Name of Facility: _____

8. Address: _____
Street City State/Prov. Postal Code

9. Admitted: ____/____/____ Discharged: ____/____/____
Month/Day/Year Month/Day/Year

10. Intensive Care: ____/____/____ Discharged: ____/____/____
Month/Day/Year Month/Day/Year

11. Convalescent Care: ____/____/____ Discharged: ____/____/____
Month/Day/Year Month/Day/Year

12. Referring Physician: _____

13. Attending Physician: _____ Degree; _____

14. Address: _____
Street City State/Prov. Postal Code

15. Phone: (____) _____ 16. Physician's Taxpayer I.D. Number: _____

Physician's Signature: **X**: _____ Date: ____/____/____
Month/Day/Year

COMMENTS: _____