Where Community and Compassion Unite

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
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 614.487.9675 • www.uct.org

Accident Medical Expense Insurance Claim Form

Dear Member:

PLEASE NOTE

This is an Accident Only Policy. Loss must be caused by accidental bodily injury and must be independent of disease, bodily infirmity or any other cause.

To help expedite the processing of your claim it is important that the following information be provided where applicable.

Emergency Room Report

Police Report if applicable (IE: Auto Accident)

Itemized Bills and Invoices

Explanation of Benefits from your primary carrier, if applicable

Physician's Statement completed, if applicable

DO YOU WANT ELIGIBLE PAYMENT OF BENEFITS ASSIGNED TO THE PROVIDER(S)?
(PLEASE CHECK THE APPROPRIATE BOX BELOW)

YES _____

NO _____

Claims can be mailed to: **UNITED COMMERCIAL TRAVELERS**
1801 WATERMARK DRIVE STE 100
P.O. BOX 159019
COLUMBUS OH 43215-8619

Claims can be faxed to: 614-487-9603

Claims can be emailed to: claimservices@uct.org

PLEASE COMPLETE IN FULL AND RETURN WITHIN 30 DAYS.

Where Community and Compassion Unite

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
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 614.487.9675 • www.uct.org

Accident Medical Expense Insurance Claim Form

PLEASE PRINT

POLICYOWNER INFORMATION (COMPLETE ALL QUESTIONS)

Today's Date (MM/DD/YYYY): _____/_____/_____

1. Name: _____ **Policy Number:** _____
   First, MI, Last
2. Address: _____
   Street City State Zip 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: _____/_____/_____

ACCIDENT INFORMATION

10. Date of Accident: _____/_____/_____ 11 Date First Treated: _____/_____/_____
    Month/Day/Year Month/Day/Year
12. Describe how accident occurred: _____

    _____
13. Area and extent of bodily injury: _____

    _____
14. Where did Accident Occur: _____
15. Did Accident Occur on the Job: ☐ Yes ☐ No
16. Do you have other insurance: ☐ Yes ☐ No

IF YOU SELECT YES TO OTHER INSURANCE PLEASE PROVIDE ALL EXPLANATION OF BENEFITS FROM YOUR INSURANCE CARRIER(S) WITH THIS CLAIM FORM.

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 Zip Code
21. Phone Number of Hospital: (_____) - _____
    Area Code

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

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) _____ (Zip Code)
9. Admitted: _____/_____/_____ (Month/Day/Year) Discharged: _____/_____/_____ (Month/Day/Year)
10. Intensive Care: _____/_____/_____ (Month/Day/Year) Discharged: _____/_____/_____ (Month/Day/Year)
11. Rehabilitation Care: _____/_____/_____ (Month/Day/Year) Discharged: _____/_____/_____ (Month/Day/Year)
12. Referring Physician: _____
13. Attending Physician: _____ Degree: _____
14. Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)
15. Phone: (_____)_____ 16. Physician's Taxpayer I.D. Number: _____

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

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.

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: _____/_____/_____
Month/Day/Year

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 documents for verification.