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
Accident Medical Expense Insurance Claim Form

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, OH 43215
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 800.948.1039 • www.uct.org

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

1. Patient’s Name: ____________________________  
2. Date of Birth: ______/______/______  
3. Diagnosis: ____________________________  
4. History of condition provided by patient: ____________________________  
5. Accident? □ Yes □ No Date: ______/______/______  
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: ______/______/______ Discharged: ______/______/______  
10. Intensive Care: ______/______/______ Discharged: ______/______/______  
11. Rehabilitation Care: ______/______/______ Discharged: ______/______/______  
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: ______/______/______  

COMMENTS

________________________________________________________________________________________

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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.