CATLIN

Insurance Claim Filing Instructions

PROOF OF ACCIDENT AND SICKNESS MEDICAL EXPENSE SHALL CONSIST OF THE FOLLOWING:

1. A completed and signed claim form
2. Official Accident, Incident, Toxicology or Medical Examiners Reports
3. Authorization to obtain medical records
4. Copy of the Ambulance report or medical report, if available
5. Itemized medical bills, which include all UB04 hospital bills, CMS 1500 / HCFA, physician bills

A PROPERLY COMPLETED CLAIM FORM WILL ASSIST US IN THE PROMPT PROCESSING OF YOUR CLAIM

Return Claim Form to:

AMA & Associates
ATTN: Claims Department
PO Box 659570
San Antonio, Texas 78265
1-800-456-7480
Fax: 210-822-4113
customerservice@amaofsa.com

Note: If you need additional space in order to complete the Claim Form, please attach a separate sheet of paper with your responses.

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Fraud Warning for Claim Forms

WARNING – Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

For AL residents:

> ***Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.***

For CA residents:

> ***Warning – Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.***

For FL residents:

> **Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

For KS residents:

> ***WARNING - Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud as determined by a court of law, which is a crime and subjects the person to civil and criminal penalties.***

For KY residents:

> **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.**

For LA residents:

> ***Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.***

For ME residents:

> ***It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.***"

For NJ residents:

> **Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.**

For NM residents:

> ***ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.***

For NC resident:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and may subject the person to civil and criminal penalties.

For OH residents:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

For OK residents:

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

For OR residents:

WARNING - Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which may be a crime and may subject the person to civil and criminal penalties.

For PA residents:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

For RI residents:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For TN residents:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For VA residents:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

For VT residents:

WARNING - Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may commit insurance fraud, which may be a crime and may subject the person to civil and criminal penalties.

Catlin Insurance Company, Inc.

A. INSURED INFORMATION

Are you a United States Citizen? No ☐ Visa Type _____ Yes ☐ Social Security Number _____

Insured's Name _____ Date of Birth: _____ Sex: ☐ Male ☐ Female
Month/Day/Year

Insured's Address _____

Home Country _____ Date of Arrival in U.S.A _____ Occupation _____
Month/Day/Year

Phone Number _____ E-mail Address _____

Name of College/University/Group: University of Wisconsin Platteville Group No. 2596 Policy No. BAH 4001819 0814

B. CLAIMANT INFORMATION

Claimant's Name _____ Relationship to Insured if a Dependent _____

Claimant's Address _____

Date of Birth _____ Social Security Number (if applicable) _____ Occupation _____
Month/Day/Year

C. OTHER INSURANCE List all Insurance Policies paying benefits for this covered loss:

Insurance Company _____ Policy Number _____

Insurance Company _____ Policy Number _____

D. AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by Catlin Insurance Company, Inc. or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I hereby authorize Catlin Insurance Company, Inc. or its authorized representative to release any information requested herein to any expert, investigator, physician, medical practitioner, hospital, medical or medical related facility, insurance company, reinsurer, plan administrator, plan sponsor or employer for the purpose of investigating and /or adjudicating this claim. A copy of this authorization shall be considered as effective and valid as the original.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Authorized Person) _____ Date _____
Month/Day/Year

Print Name Here _____

Catlin Insurance Company, Inc.

Accident Medical Expense Claim

A. DESCRIPTION OF ACCIDENT

Date of Accident _____ Time of Accident _____ Location of Accident _____
Month/Day/Year

Please describe in detail the circumstances of accident and the cause of the covered loss (attach separate sheet if needed)
Was the Injury on the left or right side of the body? ☐ Right Side ☐ Left Side _____

_____

_____

Did the Accident occur during the course of the Claimant's employment? _____
Did the Injury occur during practice or play of sports? ☐ No
☐ Yes - check: ☐ Club ☐ Intercollegiate ☐ Recreational ☐ Other -explain

Name of Sport _____ _____

Intercollegiate injuries require signature of school official: _____

B. REQUIRED ACCIDENT DOCUMENTATION

The following documents must accompany this Accident claim form: **- Policy Report (if applicable)**
- Itemized Medical Bills (See Page 1 for Instructions)

Sickness Medical Expense Claim

A. DESCRIPTION OF SICKNESS

Date when Sickness/Symptoms first occurred _____
Month/Day/Year

Type of Sickness. What prompted your need for medical treatment? _____

_____

Is this condition work related? ☐ No ☐ Yes, please explain _____

Have you had this same or similar condition before? ☐ No ☐ Yes If yes, when _____
Month/Day/Year

If previously treated for this condition, provide name and address of physician and hospital _____

_____

Were you taking any medications prior to the effective date of this insurance: ☐ No ☐ Yes If yes, please provide the following

Drug Name _____	Drug Name _____	Drug Name _____
Prescribed for _____	Prescribed for _____	Prescribed for _____
Physician Name _____	Physician Name _____	Physician Name _____
Date First Prescribed _____	Date First Prescribed _____	Date First Prescribed _____

B. REQUIRED SICKNESS DOCUMENTATION

The following document(s) must accompany this Sickness claim form: **- Itemized Medical Bills (See Page 1 for Instructions)**

CATLIN

AUTHORIZATION
FOR RELEASE OF INFORMATION

CLAIMANT (name) _____

POLICY NUMBER: _____ **BIRTH DATE:** _____
Month/Day/Year

Solely to assist Catlin Insurance Company, Inc. in administering an insurance claim, I hereby authorize any physician, doctor, dentist, clinic, hospital, pharmacy, or other medical professional, or any insurance company, employer, coroner, medical examiner, law enforcement agency, governmental agency or other person or organization possessing medical, employment, financial, insurance and/or police record information on the individual named above, to permit Catlin Insurance Company, Inc., its affiliates or its representatives, to view, copy, be furnished copies or be given details of my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This protected health information and other information includes any medical information, employment or financial information, insurance policy and claim history, and/or police record information including but not limited to, mental and physical condition, evaluation, diagnosis, treatment, prognosis, autopsy protocol and findings, and/or toxicology results; specifically to include drug, alcohol, mental illness, psychiatric treatment or diagnosis, testing, and/or treatment of HIV (AIDS virus) and/or other sexually transmitted diseases.

By my signature below, I terminate any agreements I have made with my providers to restrict my medical records and any associated HIPAA protected health information and I instruct my providers to release and disclose my entire medical record without restriction.

This protected health information and other information is to be disclosed under this Authorization so that Catlin Insurance Company, Inc. may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with Catlin Insurance Company, Inc., its subsidiaries and affiliates.

This Authorization is valid from the date signed for the duration of the claim not to exceed 24 months from the date of signature. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Catlin Insurance Company, Inc.. I understand that a revocation is not effective if any of my providers has relied on this Authorization or to the extent that Catlin Insurance Company, Inc. has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I also understand that if I refuse to sign this Authorization, Catlin Insurance Company, Inc. may not be able to process claims or properly administer coverage and may result in a denial of coverage. I understand the company will provide me with an additional copy of this Authorization.

Any copy of this Authorization shall have the same authority as the original.

Authorization given by (sign name here) : _____

Print Name Here : _____

Date Signed : _____

Relationship to Claimant : _____