Professional Insurance Company

In California, PIC Life Insurance Company

P.O. BOX 85656
LINCOLN, NE 68501-5656

800-289-1122

Claim No. _____

Policy Nos. _____ _____

CLAIMANT'S STATEMENT: **Complete for all claims**. *For Cancer Policy, please submit Pathology Report.*

Policyholder's Name _____ Date of Birth _____

Address _____ Home Phone ( ) _____

Social Security No. _____

Employer _____ Occupation _____

Answer if claim is on dependent:
Dependent's Name _____ Relationship _____ Date of Birth _____
Is dependent employed? Yes ☐ No ☐ Employer _____
Is dependent a student? Yes ☐ No ☐ School _____ Dependent SS# _____

1. CLAIM IS FOR Accident ☐ Illness ☐ Nature of illness/injury _____
2. Date of accident or 1st sign of illness _____ If claim is for an accident, describe how and where it occurred: _____
3. Has claim been made or will claim be made under any Worker's Compensation or Employers Liability Law? Yes ☐ No ☐
4. Were you hospitalized? Yes ☐ No ☐ If yes, give dates, from _____ (Mo Day Yr) to _____ (Mo Day Yr)

   Name/Address of Hospital _____

   If you were hospitalized, please send a copy of the hospital bill.
5. List all Doctors you have seen for this condition.

   Name Address Date 1st seen

   _____

   _____
6. Have you ever had symptoms of this condition before? Yes ☐ No ☐ When _____
7. Do you have insurance with any other Company? Yes ☐ No ☐ If yes, provide

   Name of Company Policy Number(s)

   _____

   _____

IMPORTANT: PLEASE SUBMIT A COPY OF THE POLICE REPORT IF THIS CLAIM IS DUE TO A VEHICLE ACCIDENT.

Complete this Section only if you are filing for disability (loss of time from work) benefits.

1. Date you stopped working due to disability _____ Date you returned, or will return, to work _____
2. Are you confined (restricted by Drs. orders) to your home? Yes ☐ No ☐
3. Average Monthly Earnings $ _____ 4. List Job Duties _____

EMPLOYER'S STATEMENT: Must be completed for disability benefits.

1. Date of first absence due to disability _____ Date Employee returned to work _____
2. Monthly Earnings _____ Date hired _____ Date of termination, if terminated _____
3. Has claim or will claim be made for Worker's Compensation Benefits? Yes ☐ No ☐
   If yes, what is status of claim? _____
4. Will you provide "light duty" if employee is released with restrictions? Yes ☐ No ☐

Name of Employer _____ Phone number of Employer ( ) _____

Authorized Signature _____ Title or Position _____ Date _____

AUTHORIZATION TO OBTAIN INFORMATION: I hereby authorize any physician or practitioner of the healing arts who has examined or treated me, and all hospitals, clinics or medically related facilities, insurance companies, health maintenance organizations, medical information bureau, government entity (federal, state or local) or other organization, institution or person, that has any information, records or knowledge of me or my health, past or present, to furnish to Professional Insurance Company (or its representatives) and to permit them to examine and copy any such information. I understand that Professional Insurance Company may disclose the information in connection with underwriting or claims processing with the company. A copy of this authorization, or the original, shall be valid for ninety (90) days from the date signed. I acknowledge that I have a right to a copy of this authorization upon request.

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.

Claimant Signature _____ Date _____

THIS CLAIM REPORT IS USED FOR ANY TYPE OF HEALTH CLAIM AND MUST BE RETURNED TO
PROFESSIONAL INSURANCE COMPANY, P.O. BOX 85656, LINCOLN, NE 68501-5656 PHONE 800-289-1122

PART A TO BE COMPLETED BY PATIENT (INSURED)

PATIENT'S NAME AND ADDRESS

INSURED'S NAME AND ADDRESS IF PATIENT IS A DEPENDENT

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGNED (PATIENT, OR PARENT IF MINOR)

DATE

PART B ATTENDING PHYSICIAN'S STATEMENT

For routine FIRST-AID claims, this side is not usually required, if a copy of the bill showing Patient's name, diagnosis, charges, and date incurred is furnished along with Claimant's Statement on reverse side.

1. DIAGNOSIS AND CONCURRENT CONDITIONS
(IF DIAGNOSIS CODE OTHER THAN ICDA USED, GIVE NAME)

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES ☐ NO ☐

3. IF CONDITION IS DUE TO ACCIDENT, PLEASE GIVE DETAILS OF ACCIDENT.

4. IS CONDITION DUE TO PREGNANCY? YES ☐ NO ☐ IF YES, EXPECTED DATE OF DELIVERY _____ DATE OF LMP _____

5. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL). IF A PREVIOUS FORM HAS BEEN SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT.

Date of Services (Mo. Day, Yr.)	Place of Services	Description of Surgical or Medical Services Rendered	Procedure Code – If used (If code other than CPT used, give name)

6. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.

7. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☐ IF "YES" WHEN AND DESCRIBE:

9. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐ IF NO, DATE LAST SEEN _____

10. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO PERFORM SUBSTANTIALLY ALL OF HIS/HER OCCUPATIONAL DUTIES)
FROM THROUGH

11. PATIENT WAS PARTIALLY DISABLED (ABLE TO PERFORM SOME BUT NOT ALL OF HIS/HER OCCUPATIONAL DUTIES)
FROM THROUGH

12. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

13. PATIENT WAS HOSPITAL CONFINED: FROM _____ TO _____
PATIENT WAS HOUSE CONFINED: FROM _____ TO _____
(HOUSE CONFINEMENT IS THE INABILITY TO LEAVE THE HOUSE EXCEPT TO OBTAIN MEDICAL TREATMENT OR TO ENGAGE IN MEDICALY PRESCRIBED ACTIVITIES THAT ARE THERAPEUTIC IN NATURE.)

14. DOES PATIENT HAVE OTHER HEALTH COVERAGE? IF "YES" PLEASE IDENTIFY

15. WAS PATIENT REFERRED TO YOU BY ANOTHER PHYSICIAN? YES ☐ NO ☐ IF YES, PLEASE PROVIDE NAME OF REFERRING PHYSICIAN

PHYSICIAN'S NAME (PLEASE PRINT) _____ IRS IDENTIFICATION NO.* _____

PHYSICIAN'S SIGNATURE _____ DEGREE _____ DATE _____

ADDRESS _____
Street City State or Province Zip Phone Number (w/area code) Fax Number (w/area code)

*THE INSERTION OF THE IRS NUMBER IS REQUIRED BY THE INTERNAL REVENUE SERVICE.