NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA

CLAIM FORM

CLAIM FOR:

☐ Accident ☐ Sickness ☐ Heart Attack/ Heart Disease/ Stroke

Insured Name		Mailing Address	
Date of Birth	Social Security Number	Telephone Number	
Claimant Name	Date of Birth	Occupation	Social Security Number

1. Describe your illness or injury?____________________

How did the injury occur:____________________

If an *injury,* the date of occurrence:__________ If an *illness,* the date you first noticed symptoms:

2. Name and address of the *first* physician you consulted this condition?____________________

3. Date, if ever, that you had similar condition before:____________________

4. If you were confined to a hospital, the hospital's name and address:____________________

Date admitted:__________ Date discharged:__________

5. Between what dates were you totally and continuously disabled? From ______, 20____ to ______, 20____

6. Between what dates were you partially disabled? From______, 20____ to ______, 20____

7. If still disabled, when do expect to resume full duties?____________________

8. List All Physicians Consulted in the Last Five Years:

Name of Doctor	Address	Telephone Number	Date

9. If Claim is on Dependent, please answer the following:
   Claim is on ☐ Dependent spouse; ☐ Dependent Child
   Does the Claimant meet definition of covered person under the policy? ☐ Yes ☐ No
   For spouse, the person must be named on the application and continually married since date of application. For child, the person must be named on the application if born prior to application. If born after application date, both must meet definition of Covered Person under the policy.

IMPORTANT: TO AVOID DELAY, PLEASE SIGN AUTHORIZATION BELOW

NOTE: DUE TO INTERNAL REVENUE SERVICE REQUIREMENTS CONCERNING SOCIAL SECURITY NUMBER VERIFICATION AND BACKUP WITHHOLDING REQUIREMENTS, THIS FORM IS REQUIRED TO BE COMPLETED PRIOR TO CLAIM PAYMENT.

1. Section 125: Were the premiums for your disability income policy paid with pre-tax dollars under a Section 125 Plan? ☐ Yes ☐ No

2. Federal Law requires us to send to the Internal Revenue Service a percentage of any income you may be entitled to unless you certify under penalties of perjury that you have shown your correct Social Security Number and you have not been notified that you are subject to an Internal Revenue Service backup withholding order.

Under Penalties of perjury, I certify that: (1) The Social Security Number shown in line (2) is correct, AND (2) ☐ I have ☐ I have not been notified by the Internal Revenue Service backup withholding order.

NOTICE TO ALL CLAIMAINTS: Any person who knowingly and with intent to defraud any insurance company or other company files an application of insurance or statement of claim containing any materially false information, or conceals for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a substantial civil penalty where and to the intent allowed by state law.

NAIC Fraud Notice:
1. "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."

2. **California Fraud Warning** "Any person who knowingly presents a 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."

3. **New York Warning** "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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

4. **Pennsylvania Warning:** "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 materials thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

You are hereby authorized to permit National Union Fire Company of Pittsburgh, PA, and Bay Bridge Administrators, LLC and its authorized representatives to view and obtain a copy of ALL RECORDS as to examination, history, diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric, drug, or alcohol treatment and disease. I agree a photographic copy of this authorization shall be valid as the original for two years.

Date__________________ 20____________ Signed (patient, or parent if minor)____________________

If someone other than patient executed this form and authorization, indicate reason:____________________

____

Relationship to Patient:____

Address:____

Mail To:
Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, Texas 78716

Please return original copy to:
Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

National Union Fire Insurance Company

Please indicate benefit applying for:

☐ **Cancer - Waiver of Premium Due to Disability**

☐ **Accident - Disability**

To Be Completed By Attending Physician

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and subject to civil or criminal penalties.

We must have comprehensive medical information in order to evaluate the insured's claim for benefits due to Disability.
Any charge required for completion of this form is the responsibility of the patient.

Name of Patient	**Date of Birth**

1. HISTORY

	Month	Day	Year
(a) When did symptoms first appear or accident happen?			
(b) Date disability commenced			

(c) Has patient ever had same or similar condition? ☐ Yes ☐ No

If "Yes" state when and describe

(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

(e) Please submit copies of all office notes since disability commenced.

2. DIAGNOSIS (including any complications)

(b) Diagnosis (including any complications and ICD 9) **If totally disabled due to pregnancy, please include delivery date and type of delivery

(c) Subjective symptoms

(d) Objective findings (including current X-rays, EKG's Laboratory Data and any clinical findings)

3. DATES OF TREATMENT

	Month	Day	Year
(a) Date of first visit			
(b) Date of last visit			

(c) Frequency ☐ Weekly ☐ Monthly ☐ Other (Specify)

4. NATURE OF TREATMENT

Please describe course of treatment.

5. PROGRESS

(a) Give prognosis with reasonable estimate of return to work date.

(b) Has patient been hospital confined? ☐ Yes ☐ No

If "Yes", give Name and Address of Hospital	Confined from	through

6 LIMITATIONS **(what the patient CANNOT do)**

7 RESTRICTIONS **(what the patient SHOULD NOT do)**

8 PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

- ☐ Class 1 - No limitation of functional capacity; capable of heavy work *No restrictions (0-10%)
- ☐ Class 2 - Medium manual activity* (15-30%)
- ☐ Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%)
- ☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
- ☐ Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)

Remarks:

9 EXTENT OF DISABILITY

	From Patient's Regular Occupation	From Any Occupation
(a) Is patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
(b) If yes, when do you think patient will be able to resume any work?	Approximate Date Mo. Day Yr.	Approximate Date Mo. Day Yr.

10 REMARKS

Signature (Attending Physician)	Specialty	Date
Name of Physician (Please Print):	Telephone Number	Fax Number
Address (Street, City or Town, State or Province, Zip Code)		Tax ID Number

Please return original form to:
Bay Bridge Administrators, LLC
PO Box 161690
Austin TX 78716
800-845-7519

EMPLOYER'S STATEMENT

National Union Fire Insurance Company

Humana Insurance Company

To be completed by Employer (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

Employee's Name	Social Security Number	Date of Birth
Employee's Home Address (Street, City, State, Zip)		

1. **Employment**		
	a. Insurance class/plan	f. Occupation as of last date worked **(Attach job description):**
	b. Employee's date of hire	g. Worked schedule at time last worked No. days per week ________ No. hours per day ________
	c. Date employee became insured	h. Reason for stopping work
	d. Date employee was actually last at work	I. Has employee returned to work? ☐ Yes ☐ No — Full-time date — Part-time date
	e. Number of hours worked on last day	j. Is employee's job being held open?

2 **Name Of Employer**		
	Name of Employer (Association or Policyholder, if other)	
	Address	
	Signature of Employee Representative **X**	Date Signed
	Printed Name and Title or Position	Employer's Telephone Number
	Email Address	Employer's Fax Number