Companion Life®

P.O. Box 100102 • Columbia, SC 29202-3102

HOSPITAL CONFINEMENT BENEFIT CLAIM

ATTACH COPY OF HOSPITAL BILLS

WHAT TYPE BENEFITS ARE BEING REQUESTED: ☐ HOSPITAL CONFINEMENT ☐ INTENSIVE CARE ☐ EXTENDED CARE FACILITY

PATIENT & INSURED INFORMATION

1. Patient's Name *(First Name, Middle Initial, Last Name)*	2. Patient's Date of Birth	3. Insured's Name *(First Name, Middle Initial, Last Name)*
4. Patient's Address *(Street, City, State, Zip Code)*	5. Patient's Sex Male ☐ ☐ Female	6. Insured's I.D.
	7. Patient's Relationship to Insured SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	8. Insured's Address *(Street, City, State, Zip Code)*

9. Describe condition for which claim is being made:

10. Date symptoms first appeared: Date, Name and Address of Doctor first seen for this condition: Date: _____ Name: _____ Address: _____

11. Has a Doctor been seen for this or similar condition in the past: ☐ Yes ☐ No If Yes, give Date, Name and Address of Doctor: Date: _____ Name: _____ Address: _____

12. Were you confined to your house as a result of this condition: ☐ Yes ☐ No If Yes, show dates: From: _____ To: _____

13. If Hospitalized,

Name of Hospital: _____ Date Admitted: _____ Date Discharged: _____

Address of Hospital: _____
Street City State Zip Code

14. If more than one Hospital Admission or Extended Care Confinement, complete the following:

Name of Medical Facility: _____ Date Admitted: _____ Date Discharged: _____

Address of Medical Facility: _____
Street City State Zip Code

If condition due to an accident, complete questions 15 and 16

15. Date of Accident: _____ Time of Accident: _____ ☐ AM ☐ PM Accident occurred: ☐ on the job ☐ off the job

16. Give specific description and location of accident:

INSURED DECEASED

☐ DEATH WAS DUE TO NATURAL CAUSES

☐ DEATH WAS DUE TO AN ACCIDENT

_____
Date of Death

WHOM SHOULD WE CONTACT

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: _____
Area Code Exchange No.

Any person who knowingly and with intent to defraud any insurance company or other person and who files an application for insurance or 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 and subjects such person to criminal and civil penalties (not applicable in MD).

PART C Insured's Authorization

I have checked the above answers and they are correct. I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to Companion Life Insurance Company or its legal representative, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by Companion Life Insurance Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by Companion Life Insurance Company 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 AGREE this Authorization shall be valid for two and one-half years from the date shown below.

Signed this _____day of _____, 19____ _____ _____
Signature of Patient Signature of Insured