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| Name of Group: UNIVERSITY OF CALIFORNIA |
| Policy Number: ADDN04223810 |
| Certificate Number: |

DISABILITY CLAIM FORM

| | | | |
|----------------------------|-----------------------|-------------|--------------|
| Insured's Full Name | Street Address | City | State |
| | | | |
| | | | |

| | | | |
|----------------------|--------------------------|-----------------------|------------------|
| Date of Birth | Height and Weight | Marital Status | Telephone |
| | | | |
| | | | |

| | | | |
|--|---------------|-------------------------|------------------------|
| Occupation Prior to Disablement | Duties | Monthly Earnings | Weekly Earnings |
| | | | |
| | | | |

1. Give full description of injury or disease from which you are now suffering. If an injury, tell when, where and how it occurred. **Sickness** **Injury**

2. (A) Have you ever had this or a similar condition in the past **Yes** **No**

| | | | |
|---|---------------------|--------------|---|
| (B) If yes, state the nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals and clinics | Condition(s) | Dates | Treating Physician & Address |
|---|---------------------|--------------|---|

| | | | |
|--|--------------|--|--------------|
| 3.(A) Give exact date when illness began or injury occurred | Date: | B. When did you first consult physician for this condition | Date: |
|--|--------------|--|--------------|

| | | | |
|---|--------------|--|--------------|
| (C) When did you become totally disabled (unable to work)? | Date: | D. When were you able to again perform part of your occupational duties? | Date: |
|---|--------------|--|--------------|

| | | |
|---|--------------|----------------|
| 4. Hospitals (give complete names addresses and date of confinement) | Names | Address |
|---|--------------|----------------|

| | | | |
|---|--------------|------------------|------------------|
| 5. (A) Give names, addresses and telephone numbers of all attending physicians | Names | Addresses | Telephone |
|---|--------------|------------------|------------------|

| | | | |
|---|-------------|----------------|------------------|
| (B) Give name, address and telephone number of usual family physician. | Name | Address | Telephone |
|---|-------------|----------------|------------------|

| | | | |
|--|-------------|----------------|----------------|
| 6. What other accident, sickness or disability insurance do you have in place. Please name the insurance carrier. | Name | Address | Benefit |
|--|-------------|----------------|----------------|

| | | | |
|--|-------------|----------------|-----------------------------|
| 7. List names, addresses of all treating physicians and hospitals during the past 5 years and the reason and date of treatment. | Name | Address | Reason for Treatment |
|--|-------------|----------------|-----------------------------|

| | | | | |
|--|--------------|------------------|-------------|-----------|
| 8. Names and address of Employers and length of Employment with each? | Names | Addresses | From | To |
|--|--------------|------------------|-------------|-----------|

ATTENDING PHYSICIAN'S STATEMENT – HEALTH INSURANCE DISABILITY CLAIM

Patient's Name and Address

Age:

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|
|

1. (A) Diagnosis and current condition
(If fracture or dislocation, describe nature and location).

(B) Is condition due to injury or sickness arising out of patient's employment? If yes explain. [] Yes [] No

2. (A) When did symptoms first appear or accident occur? Date

(B) When did patient first consult you for this condition? Date

(C) Has patient ever had same or similar condition? [] Yes [] No
If "Yes" state when and describe

3. (A) Nature of surgical procedure, if any (describe fully).

(B) If performed in hospital, give name of hospital [] Inpatient [] Outpatient

4. What other services, if any did you provide a patient?
(itemize giving dates and fees).

5. Is patient still under your care for this condition? [] Yes [] No
If "No" give date services terminated Date:

6. (A) How long was or will patient be continuously totally disabled? From Thru
(Unable to work?)

(B) How long was or will patient be partially disabled? From Thru

(C) Was house confinement necessary? If "Yes" give dates [] Yes [] No
From Thru

7. To your knowledge does patient have other health insurance or health plan coverage ? If "Yes" Identify [] Yes [] No

REMARKS

Date Print Name of Physician Specialty Telephone

Signature of Physician

Street Address City or Town State Zip Code

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I agree that a photographic copy of this Authorization shall be a valid as the original.

I understand that I or my authorized representative may request a copy of this authorization.

I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative

Dated

Address:

Fraud Warning: "It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and / or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. ACE USA Accident &Health has adopted the fraud warning language prescribed by the District of Columbia as it's generalized fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic Warning:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and / or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

The following states have required us to use state specific language as follows:

California

“For your protection California law requires the following to appear on this form:

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.

Colorado

“It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Florida

WARNING: 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.

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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Oklahoma

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

New York:

Fraud 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.”

Pennsylvania:

Fraud 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 material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Oregon

WARNING: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud

Virginia

WARNING: 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 may have violated state law.