



INDEMNITY BENEFIT CLAIM FORM

Return to:
Allied National
P.O. Box 29186
Shawnee Mission, KS
66201-9186
Phone: (888)-589-9007
individualsevice@alliednational.com

Instructions for Filing your Claim

The insured must complete, sign, and send this form with an itemized hospital bill to Allied National at the address above within 90 days of the accident or hospitalization. Itemized bills must include:

- Patient name
- Date of service
- Charge for the service
- Type of service/Procedure code/Revenue code
- Diagnosis code (ICD format)
- Health care provider name
- Health care provider address

| Insured's Information | | | | | |
|--|--|-----------|--|--|--|
| Insured's First Name | | Last Name | | Date of Birth | Social Security Number |
| Home Address | | City | | State | Zip Code |
| | | | | Is this a new address? <input type="radio"/> Yes <input type="radio"/> No | |
| Phone Number | | Email | | | |
| Patient's Information | | | | | |
| Patient's First Name | | Last Name | | Date of Birth | Relationship to Insured <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child |
| Is the claim a result of an accidental injury? <input type="radio"/> Yes <input type="radio"/> No | | | Does the accident or illness result from the patient's occupation? <input type="radio"/> Yes <input type="radio"/> No | | |
| Date of hospitalization or accident | | City | | State | |
| Provide a brief statement regarding the hospitalization or accident: (Please attach a separate page, if more space is needed.) | | | | | |
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| | | | | | |
| | | | | | |
| Information Authorization | | | | | |
| I hereby authorize any dentist, physician, insurance company, organization or plan sponsor to release any information including full copies of their records to Pan-American Life Insurance Company or its administrator for any medical treatment, services or benefits rendered or payable to me on my behalf. A copy of this authorization shall be as valid as the original. | | | | | |
| I hereby certify that the foregoing answers are true and correct, to the best of my knowledge | | | | | |
| Insured's signature | | | Patient's signature (if over 15 and not the insured) | | Date |
| | | | | | |

FRAUD WARNING

For your protection, the laws of several states, including Alaska, Connecticut, District of Columbia, Delaware, Georgia, Indiana, Illinois, Idaho, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, North Carolina, Nebraska, Nevada, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Wyoming, Wisconsin, and others require the following or substantially similar warning statement to appear on this form.

FRAUD WARNING

“Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, submits an application and/or files a statement of claim containing any false, incomplete, misleading information is guilty of insurance fraud which is a felony.”

FRAUD WARNING FOR ALABAMA AND ARKANSAS 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.”

FRAUD WARNING FOR ALASKA, MINNESOTA RESIDENTS

“A person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information is guilty of a crime and may be prosecuted under state law”

FRAUD WARNING FOR ARIZONA, NEW JERSEY RESIDENTS

“Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.”

FRAUD WARNING FOR TEXAS & CALIFORNIA and TEXAS RESIDENTS

For your protection California Law requires the following to appear in this form (for California only): “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.”

FRAUD WARNING FOR COLORADO RESIDENTS

“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. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.”

FRAUD WARNING FOR DISTRICT OF COLUMBIA, TENNESSE, VIRGINIA AND WASHINGTON RESIDENTS

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.”

FRAUD WARNING FOR FLORIDA, DELAWARE, IDAHO, INDIANA, OKLAHOMA 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.”

FRAUD WARNING FOR KENTUCKY, MASSACHUSETTS, NEBRASKA AND PENNSYLVANIA RESIDENTS

“Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.”

FRAUD WARNING FOR LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND, AND WEST VIRGINIA RESIDENTS

“Any person who knowingly or willfully 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 confinement in prison.”

FRAUD WARNING FOR OHIO 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.”

FRAUD WARNING FOR PUERTO RICO RESIDENTS

“Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.