

Return this Claim form and Itemized Medical Bills to:  
**The Manhattan Life Insurance Company**  
 5 Waterside Crossing, Third Floor  
 Windsor, CT 06095

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete or misleading information is guilty of a felony of the third degree.

**REPORT OF ACCIDENT OR SICKNESS**  
 Reverse side for attending Physician's and Employer's Statements

Policyowners's full name _____	Date of Birth _____	Height _____
Patient's full name _____	Month / day / year _____	Weight _____
What sickness or injury was suffered? _____	When did accident causing injury occur? <input type="checkbox"/> AM <input type="checkbox"/> PM _____, 20 _____	
On what date did you first notice the you were beginning to get sick, or what was date of injury? _____, 20 _____	Name of Hospital _____	
On what date were you first treated by a physician for this sickness or injury? _____, 20 _____	If hospitalized _____	
Give first date you did no work because of this sickness or injury _____	Date admitted _____	
	Date released _____	

Have you ever had the same kind of sickness or injury before?  Yes  No If "yes" when \_\_\_\_\_

**IF CLAIM IS DUE TO SICKNESS ANSWER THESE QUESTIONS**

On what date were you first confined to the house all day? \_\_\_\_\_, 20 \_\_\_\_\_

On what date were you first able to leave the house for any purpose? \_\_\_\_\_, 20 \_\_\_\_\_

On what date were you first able to do any part of your work, supervisory or otherwise? \_\_\_\_\_, 20 \_\_\_\_\_

**IF CLAIM IS DUE TO INJURY ANSWER THESE QUESTIONS**

How did the accident occur? \_\_\_\_\_

On what date were you first able to do any part of your work, supervisory or otherwise? \_\_\_\_\_, 20 \_\_\_\_\_

What duties are you now unable to perform due to this injury? \_\_\_\_\_

On what date did you resume your regular duties? \_\_\_\_\_, 20 \_\_\_\_\_

Have you had any medical or surgical advice during the past five years for any other condition?  Yes  No For what \_\_\_\_\_

When \_\_\_\_\_, 20 \_\_\_\_\_ Physician's Name and Address \_\_\_\_\_

Do you have disability or hospital insurance with other companies?  Yes  No

If "yes," give names of companies. \_\_\_\_\_ Rate of benefit \$ \_\_\_\_\_ Date of Issue: \_\_\_\_\_, 20 \_\_\_\_\_

Are you receiving a disability pension or compensation?  Yes  No

If so, for what? \_\_\_\_\_ Amount \_\_\_\_\_ Date of first payment: \_\_\_\_\_, 20 \_\_\_\_\_

Are you receiving or applying for Workmen's compensation?  Yes  No Unemployment compensation?  Yes  No

What is your occupation? \_\_\_\_\_ Average monthly earnings? \$ \_\_\_\_\_ If retired, date of retirement. \_\_\_\_\_, 20 \_\_\_\_\_

Name and address or your employer or if self-employed, full business address. \_\_\_\_\_

Has any other physician treated you for this accident or sickness?  Yes  No If so, when? \_\_\_\_\_, 20 \_\_\_\_\_

Physician's name and Address \_\_\_\_\_

I authorize any hospital, physician, or other person who has attended me or examined me to disclose to my insurer or their duly authorized representative any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment relative to my person, and to furnish copies of all hospital or medical records. I understand that in executing this authorization I waive the right for such information to be privileged.

A photocopy of this authorization shall be considered as effective and valid as the original.

Date \_\_\_\_\_, 20 \_\_\_\_\_ Patient's Signature \_\_\_\_\_

Address \_\_\_\_\_ (street and No.) \_\_\_\_\_ (City or Town) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code)

**Is Address**  
 Permanent?  
 Temporary?

Phone No. \_\_\_\_\_ Policy No's \_\_\_\_\_ Date last premium paid \_\_\_\_\_  
 (very Important)

If you leave your present address temporarily or permanently during your disability, please notify us.  
**If you were in a hospital, attach itemized bill.**  
 The furnishing of this form is for the convenience of the policyowner and is not an acknowledgement of liability or waiver of any right.

## ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE CLAIM – INDIVIDUAL

Patient's name and address	Date of birth
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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
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Diagnosis and concurrent conditions (if diagnosis code other than ICDA\* used, give name)

Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, approximate date pregnancy commenced. Date
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Report of services (or attach itemized bill) (If previous form submitted to this carrier, you need show only dates and services since last report)			Procedure code-if used (If code other than CPT** used, give name)	Charges
Date of services	place of services +	Description of surgical or medical services rendered		

O-Doctor's Office    IH- Inpatient Hospital    NH Nursing Home H- Patient's Home    OH- Outpatient Hospital    OL - Other locations *ICDA- International Classification of Diseases ** CPT - Current Procedural Terminology (Current edition)	Total charges \$ _____ Amount paid \$ _____ Balance due \$ _____
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Date symptoms first appeared or accident happened.	Date patient first consulted you for this condition.
Patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, state when and describe	Patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient was continuously totally disabled (unable to work) From _____ Thru _____	Patient was partially disabled. From _____ Thru _____
If still disabled, date patient should be able to return to work.	Patient was house confined. From _____ Thru _____

Does patient have other health coverage?  Yes  No    If "yes," please identify.

Date	Physician's name (print)	Social Security Number
Physician's signature	Degree	Telephone
Street address	City or town	State or province      Zip code

### EMPLOYER'S STATEMENT

Employee's Name \_\_\_\_\_

On what date was he able to do any part of his work, supervisory or other? \_\_\_\_\_

On what date did he first quit work entirely because of this sickness or injury? \_\_\_\_\_

On what date did he resume his regular duties? Was injury covered under workmen's compensation?    If "yes," give name and address or your compensation carrier.

Date \_\_\_\_\_, 20\_\_\_\_ Signature of Employer \_\_\_\_\_ Title \_\_\_\_\_

Name of Company \_\_\_\_\_

Phone Number \_\_\_\_\_ Address \_\_\_\_\_ (Street and Number) \_\_\_\_\_ (City or Town) \_\_\_\_\_ (State) \_\_\_\_\_ (ZIP code)



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