This form should be filled out completely and sent to:

The Cincinnati Life Insurance Company
Life & Health Claims Department
Fax: (513) 870-2969

HEALTH INSURANCE CLAIM FORM

TO BE COMPLETED BY ASSOCIATE

ABOUT YOU

Name of associate: _____ Sex: M ☐ F ☐
Address: _____ Date of birth: _____
City: _____ State: _____ Zip: _____
Clock #: _____ Home tel. no.: (____) _____
Business no.: (____) _____ Extension: _____

Check One: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

ABOUT THE PATIENT

Is patient: ☐ Yourself ☐ Your Spouse ☐ Your Child ☐ Other

If other, explain: _____

Name of dependent: _____
Date of birth: Month _____ Day _____ Year _____
Dependent's employer, if any: _____
Is dependent child a full-time student? Yes ☐ No ☐
If "Yes," indicate name of school: _____
Is dependent child married? Yes ☐ No ☐

ABOUT THE CLAIM

Claim is for: Doctor _____ Hospital _____
Is this bill a result of a sickness? Yes ☐ No ☐
Is this bill a result of an injury? Yes ☐ No ☐
Did sickness or injury arise out of or in the course of employment? Yes ☐ No ☐
If bill was the result of an injury: Date injury occurred: _____
Where injury occurred: _____
How injury occurred: _____
Was the injury the result of an automobile accident? Yes ☐ No ☐
Name of other insurance company: _____
Address: _____

ABOUT OTHER INSURANCE OR OTHER REIMBURSEMENT

Are you, your spouse or your dependent children entitled to benefits from any other kind of health insurance plan, including union welfare plans or school insurance? Yes ☐ No ☐
If "Yes," answer A and B below.
A. Identify family member insured under other policy: _____
B. Name of other insurance company: _____ Policy no.: _____
Address: _____ Effective date: _____
City: _____ State: _____
Zip: _____
C. Is the CFC Health Plan: Primary ☐ Secondary ☐

ASSOCIATE'S SIGNATURE

I will abide by the provisions set forth in the Summary Plan Description and Plan Document. I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above.

Associate's signature _____ **Date** _____

ATTENTION

Any person who intends to defraud or knowingly facilitates fraud against an insurer by submitting an application or filing a claim containing a false or deceptive statement is guilty of insurance fraud.