

# Professional Insurance Company

In California, PIC Life Insurance Company

P.O. BOX 85656  
LINCOLN, NE 68501-5656

800-289-1122

Claim No. \_\_\_\_\_

Policy Nos. \_\_\_\_\_

## CLAIMANT'S STATEMENT: Complete for all claims. For Cancer Policy, please submit Pathology Report.

Policyholder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Social Security No. \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Answer if } Dependent's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

claim is on } Is dependent employed? Yes  No  Employer \_\_\_\_\_

dependent } Is dependent a student? Yes  No  School \_\_\_\_\_ Dependent SS# \_\_\_\_\_

1. CLAIM IS FOR Accident  Illness  Nature of illness/injury \_\_\_\_\_

2. Date of accident or 1<sup>st</sup> sign of illness \_\_\_\_\_ If claim is for an accident, describe how and where it occurred: \_\_\_\_\_

3. Has claim been made or will claim be made under any Worker's Compensation or Employers Liability Law? Yes  No

4. Were you hospitalized? Yes  No  If yes, give dates, from \_\_\_\_\_ to \_\_\_\_\_  
Mo Day Yr Mo Day Yr

Name/Address of Hospital \_\_\_\_\_

*If you were hospitalized, please send a copy of the hospital bill.*

5. List all Doctors you have seen for this condition.  
Name Address Date 1st seen

6. Have you ever had symptoms of this condition before? Yes  No  When \_\_\_\_\_

7. Do you have insurance with any other Company? Yes  No  If yes, provide  
Name of Company Policy Number(s)

## IMPORTANT: PLEASE SUBMIT A COPY OF THE POLICE REPORT IF THIS CLAIM IS DUE TO A VEHICLE ACCIDENT.

### Complete this Section only if you are filing for disability (loss of time from work) benefits.

1. Date you stopped working due to disability \_\_\_\_\_ Date you returned, or will return, to work \_\_\_\_\_

2. Are you confined (restricted by Drs. orders) to your home? Yes  No

3. Average Monthly Earnings \$ \_\_\_\_\_ 4. List Job Duties \_\_\_\_\_

### EMPLOYER'S STATEMENT: Must be completed for disability benefits.

1. Date of first absence due to disability \_\_\_\_\_ Date Employee returned to work \_\_\_\_\_

2. Monthly Earnings \_\_\_\_\_ Date hired \_\_\_\_\_ Date of termination, if terminated \_\_\_\_\_

3. Has claim or will claim be made for Worker's Compensation Benefits? Yes  No   
If yes, what is status of claim? \_\_\_\_\_

4. Will you provide "light duty" if employee is released with restrictions? Yes  No

Name of Employer \_\_\_\_\_ Phone number of Employer ( ) \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Title or Position \_\_\_\_\_ Date \_\_\_\_\_

AUTHORIZATION TO OBTAIN INFORMATION: I hereby authorize any physician or practitioner of the healing arts who has examined or treated me, and all hospitals, clinics or medically related facilities, insurance companies, health maintenance organizations, medical information bureau, government entity (federal, state or local) or other organization, institution or person, that has any information, records or knowledge of me or my health, past or present, to furnish to Professional Insurance Company (or its representatives) and to permit them to examine and copy any such information. I understand that Professional Insurance Company may disclose the information in connection with underwriting or claims processing with the company. A copy of this authorization, or the original, shall be valid for ninety (90) days from the date signed. I acknowledge that I have a right to a copy of this authorization upon request.

ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF COMMITTING A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECT TO CRIMINAL PROSECUTION.

Claimant Signature \_\_\_\_\_ Date \_\_\_\_\_

**PART A TO BE COMPLETED BY PATIENT (INSURED)**

PATIENT'S NAME AND ADDRESS \_\_\_\_\_

INSURED'S NAME AND ADDRESS IF PATIENT IS A DEPENDENT \_\_\_\_\_

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 \_\_\_\_\_

**PART B ATTENDING PHYSICIAN'S STATEMENT**

For routine FIRST-AID claims, this side is not usually required, if a copy of the bill showing Patient's name, diagnosis, charges, and date incurred is furnished along with Claimant's Statement on reverse side.

1. DIAGNOSIS AND CONCURRENT CONDITIONS  
 (IF DIAGNOSIS CODE OTHER THAN ICDA USED, GIVE NAME)

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING  
 OUT OF PATIENT'S EMPLOYMENT? YES  NO

3. IF CONDITION IS DUE TO ACCIDENT, PLEASE GIVE DETAILS OF  
 ACCIDENT.

4. IS CONDITION DUE TO PREGNANCY? YES  NO  IF YES, EXPECTED DATE OF DELIVERY \_\_\_\_\_ DATE OF LMP \_\_\_\_\_

5. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL). IF A PREVIOUS FORM HAS BEEN SUBMITTED TO THIS CARRIER, YOU  
 NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT.

| Date of<br>Services<br>(Mo. Day, Yr.) | Place of<br>Services | Description of Surgical or Medical Services Rendered | Procedure Code –<br>If used (If code other<br>than CPT used, give name) |
|---------------------------------------|----------------------|--|---|
| _____                                 | _____                | _____  | _____   |
| _____                                 | _____                | _____  | _____   |
| _____                                 | _____                | _____  | _____   |

6. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.

7. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?  
 YES  NO  IF "YES" WHEN AND DESCRIBE:

9. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?  
 YES  NO  IF NO, DATE LAST SEEN \_\_\_\_\_

10. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED  
 (UNABLE TO PERFORM SUBSTANTIALLY ALL OF HIS/HER  
 OCCUPATIONAL DUTIES)

11. PATIENT WAS PARTIALLY DISABLED (ABLE TO PERFORM SOME  
 BUT NOT ALL OF HIS/HER OCCUPATIONAL DUTIES)

FROM \_\_\_\_\_ THROUGH \_\_\_\_\_

FROM \_\_\_\_\_ THROUGH \_\_\_\_\_

12. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE  
 TO RETURN TO WORK.

13. PATIENT WAS HOSPITAL CONFINED: FROM \_\_\_\_\_ TO \_\_\_\_\_  
 PATIENT WAS HOUSE CONFINED: FROM \_\_\_\_\_ TO \_\_\_\_\_  
 (HOUSE CONFINEMENT IS THE INABILITY TO LEAVE THE HOUSE EXCEPT TO OBTAIN  
 MEDICAL TREATMENT OR TO ENGAGE IN MEDICALY PRESCRIBED ACTIVITIES THAT  
 ARE THERAPEUTIC IN NATURE.)

14. DOES PATIENT HAVE OTHER HEALTH COVERAGE?  
 IF "YES" PLEASE IDENTIFY

15. WAS PATIENT REFERRED TO YOU BY ANOTHER PHYSICIAN?  
 YES  NO  IF YES, PLEASE PROVIDE NAME OF REFERRING  
 PHYSICIAN

PHYSICIAN'S NAME (PLEASE PRINT) \_\_\_\_\_ IRS IDENTIFICATION NO.\* \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DEGREE \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
 Street City State or Province Zip Phone Number (w/area code) Fax Number (w/area code)

\*THE INSERTION OF THE IRS NUMBER IS REQUIRED BY THE INTERNAL REVENUE SERVICE.