SET SEG
School Insurance Specialists

HOSPITAL INDEMNITY CLAIM REPORT

CLAIMANT'S STATEMENT *Please print*

INSURED NAME | SOCIAL SECURITY NUMBER | BIRTHDATE | GENDER | PHONE

ADDRESS | CITY | STATE | ZIP

PATIENT NAME (IF DIFFERENT) | RELATION | BIRTHDATE | GENDER | PHONE

ACCIDENT SICKNESS START DATE | NATURE OF SICKNESS OR INJURY

If injured, how and where did accident happen?_____

If illness, when were you first troubled with this disease?_____

When did you first obtain treatment?_____

Have you ever had the same or a similar treatment? ☐ YES ☐ NO If yes, date?_____

NAME OF PHYSICIAN CONSULTED FOR THIS CONDITION | ADDRESS | CITY | STATE | ZIP

NAME OF PHYSICIAN CONSULTED FOR THIS CONDITION | ADDRESS | CITY | STATE | ZIP

NAME OF HOSPITAL | CONFINEMENT DATES | ADDRESS | CITY | STATE | ZIP

IMPORTANT: Attach copy of hospital bill to this form

I understand and agree that any hospital, physician, or other person who has attended or examined me may furnish to Associated Mutual or its representative, any and all information about illness or injury I may have suffered, medical history, consults, prescriptions, or treatments, including X-rays and copies of all hospital or medical records. Associated Mutual may also release information in its files to its reinsureres including the information obtained here. A copy of this acknowledgement is as effective and valid as the original.

PATIENT SIGNATURE (PARENT, IF MINOR) | DATE

ATTENDING PHYSICIAN'S STATEMENT *(This portion **must be** completed before the claim will be processed)*

PATIENT NAME | AGE | HOSPITAL CONFINEMENT DATES | DATE OF FIRST CONSULT FOR CONDITION

Nature of sickness (describe any complications):_____ Date the symptoms/accident started:_____

Describe any other disease or infirmity affecting present condition:_____

Has the patient ever had same or related condition? ☐ YES ☐ NO If yes, date:_____

Describe:_____

Is confinement due to pregnancy? ☐ YES ☐ NO Conception date:_____ Referring physician name:_____

REFERRING PHYSICIAN ADDRESS | CITY | STATE | ZIP

Office treatment dates:_____ Hospital treatment dates:_____

ATTENDING PHYSICIAN SIGNATURE | DATE | ID#

EMPLOYER'S OR ADMINISTRATOR'S STATEMENT *(This portion **must be** completed before the claim will be processed)*

EMPLOYEE NAME | OCCUPATION | SOCIAL SECURITY

Benefit amount:_____ Has insured's employment terminated? ☐ YES ☐ NO If yes, date:_____

Reason:_____

Do you recommend payment of this claim? ☐ YES ☐ NO Explain:_____

EMPLOYER | PHONE | NAME | TITLE

ADDRESS | CITY | STATE | ZIP | DATE

REV. 10/13/14

For questions or to submit form: email enrollment@setseg.org or fax (517) 492-0872