CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427, Columbia,South Carolina 29202
Phone (866) 849-0011 Fax (866) 849-2970

CLAIM FORM

Accident and Supplemental Hospital and Medical Indemnity Claim Instructions

1. To ensure your claim gets processed efficiently, please check the appropriate box for the coverage you are filing a claim under. If both, please check both boxes.
   Accident Hospital Indemnity
2. Please complete the claim form below in its entirety (if information is missing, it may delay the processing of your claim).
3. Be sure to sign and date the authorization and claim form.
4. Provide the date and description of your accident or onset of illness.
5. Please provide Physician's documentation to support your accident.
6. If you are filing for an accident due to a motor vehicle collision, provide the police report. If your accident occurred on the job, provide the first report of injury.
7. Provide documentation of your first date of treatment following the accident.
8. Provide all bills associated with your claim, including treatment dates, total charges, diagnoses and procedure codes.
9. If you are filing for hospital admission/confinement benefits, include the hospital bill with admission and discharge dates and room and board charges.
10. If you are filing for specific loss benefits, provide the objective test findings, to include X-ray reports, MRIs, and CT scans. If filing for surgery benefits provide the operative report.

PART A — CERTIFICATEHOLDER/CLAIMANT'S STATEMENT

1
EMPLOYER'S NAME
CERTIFICATEHOLDER'S E-MAIL ADDRESS

2
CERTIFICATEHOLDER'S NAME | CERTIFICATE NO. | SOCIAL SECURITY/ ID #: | DATE OF BIRTH | GENDER

3
CERTIFICATEHOLDER'S ADDRESS STREET CITY STATE ZIP CODE

4
CLAIMANT'S NAME (PERSON WHO IS SICK OR INJURED) | DATE OF BIRTH | RELATIONSHIP TO CERTIFICATEHOLDER | CERTIFICATEHOLDER'S TELEPHONE NO. (WITH AREA CODE)

5
DESCRIBE WHEN AND HOW YOUR ACCIDENT OCCURRED OR THE ONSET AND NATURE OF YOUR ILLNESS.

6
IS YOUR ACCIDENT OR SICKNESS RELATED TO YOUR OCCUPATION
☐ NO ☐ YES

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED?
☐ NO
☐ YES STATUS ☐ APPROVED ☐ PENDING ☐ DENIED

7
DATE SYMPTOMS FIRST APPEARED

DOCTOR TREATED OR REFERRED BY WITHIN THE LAST YEAR:

DATE	NAME	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.

IF HOSPITALIZED WITHIN THE LAST YEAR:

DATE	NAME	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.

AUTHORIZATION

8
Several states require that the following statement appear on the claim forms:
Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included with this form.

Certificateholder's Signature: _____ Date: _____

Claimant's Signature: _____ Date: _____