HM WORKSITE ADVANTAGE
ACCIDENT AND SUPPLEMENTAL HOSPITAL INDEMNITY CLAIM FORM

DIRECTIONS

1. Complete all sections below, and read and sign the Authorization. The Authorization will be used in obtaining the information needed to process your claim. Failure to complete this section will result in a processing delay.
2. If your loss is the result of an accident, please provide a complete description of your accident. If the accident was a motor vehicle accident, attach a copy of the police or accident report. If you were injured on the job or if this was an occupational injury, attach a copy of the first report of injury filed with your employer.
3. If you were first treated at an emergency room, attach a copy of the discharge papers from the hospital in order for us to verify the first date of treatment.
4. Attach a copy of all bills and supporting documentation related to the treatment of your loss. The medical bills and supporting documents should include the diagnosis, the specific procedure or the treatment the covered insured received, the date of service and the amount charged for physician services, emergency room treatment and supplies. If you are filing for hospital confinement benefits, attach a copy of the itemized hospital bill showing the number of days of hospitalization or an admission and discharge summary.
5. If you are filing during the first year of your coverage (based on effective date) and are subject to a pre-existing condition investigation, complete the enclosed pre-existing condition statement form in full and return it to our office with your claim form.

POLICYHOLDER'S/CLAIMANT'S STATEMENT

Policyholder's Name	Policy/Certificate #	Social Security #	Date of Birth	Sex

Policyholder's Address	City	State	Zip Code

Claimant's Name (*person who is sick/injured*)	Date of Birth	Relationship to Policyholder	Policyholder Telephone

Describe when and how your accident occurred or the onset and nature of your illness.

Is your accident or sickness related to your occupation? ❒ Yes ❒ No	Has a Workers' Compensation claim been filed? ❒ Yes ❒ No	Date Symptoms First Appeared

Doctor(s) treated or referred by within the last year. *(Attach additional sheets, as necessary.)*

Date	Name	Address	City	State	Zip Code	Phone Number

If hospitalized within the last year. *(Attach additional sheets, as necessary.)*

Date	Name	Address	City	State	Zip Code	Phone Number

AUTHORIZATION

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 have checked the answers I have provided, and they are correct. I AUTHORIZE any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment and any non-medical information of me, to give HM Life Insurance Company or its legal representative, any and all such information. This information is to include, but is not limited to, information pertaining to diagnosis, care or treatment for a psychiatric disorder, drug or alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or other sexually transmitted diseases, including case history and medical antecedents. Any information obtained will not be released by HM Life Insurance Company to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may otherwise lawfully be required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this authorization shall be as valid as the original. I AGREE that this Authorization shall be valid for the duration of my claim.

Policyholder's Signature ______________________ Date __________

Claimant's Signature ______________________ Date __________

Administered by/Mail Completed Form to:

Continental American Insurance Company
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Columbia, South Carolina 29202
(866) 849-2954
E-mail: CSC@caicworksite.com