Nationwide®

Attention: Co-ordinated Benefit Plans, LLC
On Behalf of Nationwide Mutual Insurance Company and Affiliated Companies
P.O. Box 26222, Tampa, FL 33623;
Or E-mail your information to: Team1@cbpinsure.com

iNext

HOW TO FILE YOUR DISMEMBERMENT AND LOSS OF USE CLAIM:

1. **COMPLETE:** Claimant Section on the front of this form.
2. **READ & SIGN:** the Authorization and Legal notice section on the back of this form.
3. **HAVE YOUR DOCTOR:** complete the Physician's Statement on the back of this form.
4. **ANSWER ALL QUESTIONS:** missing information will cause a delay in your claim.
5. **SIGNATURE OF AUTHORIZED PROGRAM ADMINISTRATOR:** This is the primary policyholder for the traveling group.
6. **FORWARD:** this form to the claim administrator whose address is shown at the top of this form.
7. **CALL IF YOU HAVE ANY QUESTIONS:**

866-723-3063
(direct dial 727-412-7378)

Claimant Section:

School's Name: _____

Insured's Name: _____

Social Security #: _____ Date of Birth: _____

Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other _____

Policy #: _____

Phone Number: (_____)_____

Address: _____

_____

_____

Check if this is a new address ☐

Date of Accident: _____

Date of Dismemberment/Loss of Use: _____

Describe how the Accident occurred (provide accident report or supporting documents: _____

Hospital Confined: ☐ Yes ☐ No

If Yes, Dates: _______________ to _______________

Name and Address of Hospital: _____

Authorized Program Administrator's Signature:

_____ Date:_____

For completion by Claim Administrator:

Name of Insured Participant:_____ Policy #: _____

Date of Birth: _____

Effective Date of Insurance: _____ Premium Paid to Date: _____

Date of Accident: _____

THIS STATEMENT HAS BEEN REVIEWED AND TO THE BEST OF OUR KNOWLEDGE AND BELIEF IS COMPLETE AND ACCURATE

Name of Claim Administrator: _____ Phone Number: (_____)_____

Address: _____

Signature: _____ Title: _____ Date: _____

Authorization & Legal Notifications

(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(**Louisiana**) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

AUTHORIZATION: In order to determine eligibility for claim benefits, claim payment amounts, and identification and prevention of potential fraudulent activity:

1. I authorize any physician; hospital or other medical or medically related facility or provider; insurance company; insurance support organization or fraud information clearinghouse to release to: the insurance company(ies) underwriting the policy, its representatives or business associates assisting in the processing of the claim, any information regarding the medical history, symptoms, treatment, examination results or diagnosis or such other information needed to determine claim benefits for the deceased named below; and

2. I authorize the insurance company(ies) underwriting the policy, its representatives or business associates assisting in the processing of the claim, to disclose the claims information submitted to the insurance company(ies), its representatives or business associates assisting in the processing of the claim, to any insurance support organization or fraud information clearinghouse utilized by the insurance company(ies), or its representatives or business associates. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for a period not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization and that I may revoke this authorization at any time for information not then obtained upon providing written notice of such revocation of the authorization to the insurance company(ies) underwriting the policy, its representatives or business associates assisting in the processing of the claim.

➡ **Signature of claimant**: _____ Date: _____

ATTENDING PHYSICIAN'S STATEMENT
(this form is to be completed without expense to the Company)

Name of Patient _____ Date of Birth _____

Address _____
(No. & Street) (City) (State) (Zipcode)

1. NATURE OF LOSS (Describe Complications if any) _____

2. WAS THE LOSS THE RESULT OF AN ACCIDENT? ☐ Yes ☐ No

   IF YES, GIVE DATE AND NATURE OF ACCIDENT _____

3. DID THE ACCIDENTAL INJURY RESULT IN THE SEVERENCE, OR TOTAL AND PERMANENT LOSS OF USE OF THE PATIENT'S HAND, ARM, THUMB/INDEX FINGER, LEG, TOE, EYE, EAR, SPEECH OR HEARING? ☐ Yes ☐ No

   A. IF SEVERENCE, GIVE EXACT LOCATION AND MODE OF SEVERENCE _____

   B. IF LOSS OF USE, DESCRIBE LOSS INCLUDING CAUSE _____

   C. DO YOU BELIEVE VISION CAN BE RESTORED IN WHOLE OR IN PART BY TREATMENT OR SURGERY? ☐ Yes ☐ No
   IF SURGERY IS CONTEMPLATED, GIVE NATURE AND APPROXIMATE DATE: _____

4. IN YOUR OPINION, WAS ANY DISEASE, INFECTION, OR BODILY OR MENTAL INFIRMITY, AN UNDERLYING OR CONTRIBUTING CAUSE IN THE LOSS(ES) INDICATED ABOVE? ☐ Yes ☐ No

   IF YES, PLEASE EXPLAIN _____

5. IN YOUR OPINION, DID THE LOSS(ES) RESULT FROM ANY INTENTIONAL SELF-INFLICTED INJURY OR ATTEMPTED SELF-DESTRUCTION? ☐ Yes ☐ No

6. WAS THE PATIENT CONFINED TO A HOSPITAL AS A RESULT OF THE LOSS? ☐ Yes ☐ No

   IF YES, NAME AND ADDRESS OF HOSPITAL _____

PLEASE ATTACH COPIES OF YOUR OFFICE RECORDS IN CONNECTION WITH THIS ACCIDENTAL INJURY

PHYSICIANS NAME (Please print) _____ OFFICE TELEPHONE _____

ADDRESS _____

PHYSICIAN'S SIGNATURE _____ DEGREE _____ DATE _____

Insured or Authorized Representative: Sign this form and return with the claim form to:

Attention: Co-ordinated Benefit Plans, LLC
On Behalf of Nationwide Mutual Insurance Company and Affiliated Companies
P.O. Box 26222
Tampa, FL 33623
Or E-mail your information to: Team1@cbpinsure.com Or Fax to: 800-560-6340

Please keep a copy of this form for your records.

AUTHORIZATION FOR USES AND DISCLOSURES OF MEDICAL INFORMATION

To: Nationwide Mutual Insurance Company and affiliated companies ("Insurer")

I hereby give Insurer permission to obtain, use and/or disclose the below Insured's personal health information as follows:

- This authorization was prepared at the request of Insurer for the purpose of evaluating contestability and/or eligibility for benefits.
- The information that is the subject of this authorization and which will be used or disclosed as set forth below includes the release of **all medical records** (except psychotherapy notes), including, but not limited to, those containing medical history, diagnoses, symptoms, treatments, prescription drug information alcohol or drug or tobacco use or abuse or information regarding communicable or infectious conditions, such as AIDS.
- The following person(s) or group of persons employed or working for, or on behalf of Insurer may obtain, use or disclose the Insured's personal health information which is described above: Any physicians, medical practitioners, hospitals, clinics, medical or medically related facilities, paramedic facilities, treatment or recovery centers, governmental agencies, insurance support organizations, medical record retrieval services, pharmaceutical services, plan administrators, insurance companies, reinsurers, independent medical consultant or counsel and consumer reporting agencies such as the Medical Information Bureau.
- I understand that if the person or entity that gives or receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Insurer in reliance on this authorization, by sending a written revocation to: Nationwide Claims Administration, P.O. Box 6866, Shawnee Mission, KS 66206
- I understand that I am not required to sign this authorization form and that Insurer will not condition the provision of payment of benefits on the signing of this authorization, except that Insurer may condition evaluating contestability or insurance coverage eligibility for benefits on provision of this authorization if the authorization sought is for insurance coverage contestability evaluation or insurance coverage eligibility relating to the Insured. This authorization will expire 24 months from the date this authorization is signed.

Insured's Name (Print)	Insured's Date of Birth
Authorized Representative's Name (Print)	**Relationship to Insured**
Signature of Insured or Authorized Representative	Date