



INSURED'S STATEMENT

YOUR APPLICATION FOR BENEFITS WILL BE DELAYED UNLESS ALL QUESTIONS ARE FULLY COMPLETED.

1. PATIENT'S NAME		2. RELATIONSHIP TO INSURED Self Spouse Child Other		3. SEX M F		4. PATIENT'S BIRTHDATE MO DAY YEAR			5. IF FULL TIME STUDENT School City		
6. INSURED'S NAME						7. POLICY NUMBERS					
8. INSURED'S MAILING ADDRESS Street City, State, Zip						9. INSURED'S SOCIAL SECURITY NUMBER				DRIVER'S LICENSE #	
						10. INSURED'S TELEPHONE NUMBER				11. Average Monthly Income	
12. IF CONFINED, HOSPITAL NAME AND ADDRESS DATES OF CONFINEMENT: FROM _____ TO _____						13. INCOME FROM OTHER SOURCES, INCLUDING DISABILITY PLANS					
14. IF COVERED BY OTHER SIMILAR INSURANCE, INDICATE COMPANY NAME AND ADDRESS (LIST ALL OTHERS)						15. WAS TREATMENT REQUIRED BECAUSE OF AN INJURY <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, DID INJURY OCCUR WHILE AT WORK <input type="checkbox"/> Yes <input type="checkbox"/> No DESCRIBE HOW, WHEN AND WHERE INJURY HAPPENED					

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is subject to prosecution and punishment for insurance fraud.

AUTHORIZATION

I hereby authorize any physician, hospital, pharmacy, employer, dentist, coroner/medical examiner, law enforcement agency, insurance organization, consumer reporting agency, or other person or entity possessing any medical information, any information about insurance policies/benefits, or any other information to release all information of Kanawha Insurance Company. This includes any drug, alcohol, psychiatric, HIV infection or AIDS related treatment. A photocopy shall be as valid as the original. The authorization is valid 6 months from the date signed.

_____ Date _____ Signature _____ Address _____
If signed on behalf of another, give relationship: _____

EMPLOYER'S STATEMENT

1. EMPLOYEE'S NAME		2. DATE EMPLOYED	
		DATE TERMINATED	
3. JOB TITLE AND DUTIES			
4. WAS THIS AN INJURY <input type="checkbox"/> Yes <input type="checkbox"/> No		DETAILS	
5. DATE LAST WORKED	6. HAS EMPLOYEE RETURNED TO WORK <input type="checkbox"/> Yes <input type="checkbox"/> No	7. DATE RETURNED TO WORK	

COMPANY NAME & ADDRESS _____ COMPLETED BY: _____
Signature _____
Date _____
Telephone _____

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INSTRUCTIONS FOR FILING A CLAIM

Section 1 - Insured's Statement: Must be completed each time you file a claim. Be sure to answer every question. Sign and date the AUTHORIZATION for your doctor to release information to KANAWHA.

Section 2 - Employer's Statement: Required only when you are filing a claim for Disability Benefits. This section must be fully completed by your supervisor or personnel office staff. Benefits cannot be paid beyond the date this section is completed.

Section 3 - Assignment of Benefits: Complete items 1, 2 and 3. If you wish to assign benefits to your doctor sign and date item 4.

Section 4 - Physician's Statement: Ask your doctor to complete this section. All questions should be answered.

SPECIAL INSTRUCTIONS:

Cancer Policy: Positive proof of Cancer must be furnished to establish a claim. Positive proof may consist of a pathology report or, in the event no surgery was performed, laboratory or X-ray reports. These reports must be attached to the claim form.

Any Policy providing benefits based on hospital confinement or indemnity benefits: Itemized copies of your bills must be attached to the claim form.

