

Policy Number _____

Name of Insured _____

Mailing Address _____

_____ City _____ State _____ Zip _____

Name of Patient _____ Relationship _____ Date of Birth _____

1. Have you ever had this condition or a similar condition before? If yes, please provide complete details.

2. Date on which symptoms were first noticed.

3. Date of first treatment.

4. Names and addresses of physicians or practitioners consulted for this condition.

5. Name of hospitals and date of confinement for this condition.

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 to 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: _____

SEE REVERSE SIDE FOR ASSIGNMENT OF BENEFITS

INSTRUCTIONS FOR FILING A CLAIM

HOSPITAL CONFINEMENT: Submit itemized inpatient hospital bill attached to a claim form.

SURGEON/PHYSICAL: Complete Attending Physician's Statement or similar form using Current Procedural Terminology (CPT-4) Codes for all surgical procedures. All statements and reports should be attached to a claim form.

OTHER COVERED EXPENSES: furnish itemized details of service rendered and charge for each service or visit. All items should be attached to a claim form.

Positive proof of cancer must be furnished to establish a claim. Generally, proof is a pathologist's report or, in the event the cancer was diagnosed without surgery, laboratory and x-ray examination reports used to make the definitive diagnosis of cancer. All reports should be attached to a claim form.

Mail completed claims and other documentation (attached to claim forms) to:

KANAWHA INSURANCE COMPANY
ATTENTION: BENEFITS DEPARTMENT
POST OFFICE BOX 2000
LANCASTER SC 29721-2000

ATTENDING PHYSICIAN'S REPORT

HEALTH INSURANCE FORM - CRITICAL ILLNESS

PART A TO BE COMPLETED BY PATIENT (INSURED)

PATIENT'S NAME AND ADDRESS	DATE OF BIRTH
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INSURED'S NAME IF PATIENT IS A DEPENDENT _____

NAME OF INSURANCE COMPANY Kanawha Insurance Company	POLICY NUMBER	INSURED'S SOCIAL SECURITY NUMBER
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AUTHORIZATION TO PAY BENEFITS TO HOSPITAL AND PHYSICIANS: I further authorize payment directly to the hospital and Physician(s) accepting this assignment of all hospitalization and medical benefits applicable and otherwise payable to me, but not to exceed the REASONABLE AND CUSTOMARY CHARGE for these services rendered by said hospital and Physician(s) as indicated in the following Physician's Report and any attached statements of charges for medical services.

SIGNED (INSURED PERSON) _____ DATE _____

PART B ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS (if diagnosis code other than ICDA* used, give name): _____

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? Yes No PREGNANCY? If Yes, approximate date Yes No pregnancy commenced.

3. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (if previous form submitted to this carrier, you need show only dates and services since last report).

DATE OF SERVICES	PLACE OF SERVICES†	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	CPT-4 PROCEDURE CODE	CHARGES
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If Laceration—Show Size or No. of Sutures _____

If Skin Graft—Show Area and Type of Graft _____

TOTAL CHARGES→ \$ _____

AMOUNT PAID→ \$ _____

BALANCE DUE→ \$ _____

†O—Doctor's Office IH—Inpatient Hospital NH—Nursing Home

H—Patient's Home OH—Outpatient Hospital OL—Other Locations

*ICDA—International Classification of Diseases

4. DATE SYMPTOMS FIRST APPEARED _____ 5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION: _____

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION? Yes No If "Yes" when and describe: _____ 7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? Yes No

8. Has patient been treated by another physician? Yes No If so, by whom? _____

9. Was patient referred to you? Yes No If so, by whom? _____

10. Was this an injury? Yes No Give details _____

11. I DO NOT ACCEPT ASSIGNMENT.

DATE _____ PHYSICIAN'S NAME (PRINT) _____ SIGNATURE _____ DEGREE _____ TELEPHONE _____

STREET ADDRESS _____ CITY OR TOWN _____ STATE OR PROVINCE _____ ZIP CODE _____