

My Claim Is For: Nursing Home Benefits Hospice Benefits Bed Reservation Benefits Adult Day Care Benefits
 Home Health Care Benefits (If Provided By Policy) Homemaker Benefits (If Provided By Policy)
 Alternative Plan Of Care Benefits (If Provided By Policy) Assisted Living Care Facility Benefits (If Provided by Policy)
Please contact your agent or Kanawha's Home Office if you wish to request this benefit.

INSTRUCTIONS FOR FILING A CLAIM

1. Please complete the front side of this form.
 2. Have your doctor complete Part 2 on the back of this form.
- The following sections are to be completed for each item for which you are making a claim.**
3. Have the nursing home, hospice or other covered facility's director complete Part 3.
 4. Have the home health care director complete Part 4.
 5. Please send us the completed form along with bills for services covered by your policy.

PART 1 INSURED PERSON'S STATEMENT

Insured _____ Date of Birth _____

Insured's Address _____
Street or P.O. Box Apt. No. City/State Zip Code

The above address is my Personal Residence or Nursing Home or Other Facility

Insured's Telephone Number (____) _____ This is my Home Telephone or Contact Telephone

Person Holding Power of Attorney or Guardianship _____
(Name)

Address _____ Daytime Telephone (____) _____
Street or P.O. Box Apt. No. City/State Zip Code

INSURED'S STATEMENT REGARDING CLAIM

Cause of Claim Illness Injury Onset Date _____ First Treatment _____

Nature of Illness or Injury _____

Physician or Practitioner _____ Date First Seen _____

Address _____ Telephone (____) _____

Nursing Facility _____ City/State _____

Telephone (____) _____ From _____ To _____

Hospice _____ City/State _____

Telephone (____) _____ From _____ To _____

Home Health Care Agency _____ City/State _____

Telephone (____) _____ From _____ To _____

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 TO RELEASE INFORMATION

I hereby authorize any physician, practitioner, hospital, nursing facility, assisted living care facility, hospice, home health care agency, pharmacy, insurance organization, consumer reporting agency, employer, or other person or entity possessing any medical information about me to release all information to Kanawha Insurance Company. This includes, but is not limited to, any drug, alcohol, psychiatric, HIV infection or AIDS related treatment. A photocopy of this authorization shall be as valid as the original. The authorization shall be valid for one year from the date signed.

Date _____ Signature of Insured _____

Date _____ Signature Of Person Signing For Insured _____ Relationship Attorney-In-Fact
 Guardian
 Other

If you are submitting claim as attorney-in-fact or guardian, please attach a certified copy of the power of attorney or letters of guardianship with the first claim submitted.

PART 2**ATTENDING PHYSICIAN'S STATEMENT**

Patient Name _____ Date of Birth _____

ICD Diagnosis and Concurrent Conditions (If diagnosis code other than ICD used, give name.) _____

Activities of Daily Living — Please indicate areas of daily living with which the patient requires assistance.*Bathing* — means washing, including a sponge bath, with or without extra equipment. Yes No Comment _____*Continence* — Maintenance of reasonable bowel/bladder personal hygiene. Yes No Comment _____*Dressing* — putting on and taking off clothing. Yes No Comment _____*Feeding* — consuming prepared food with or without adaptive utensils. Does not include preparation and cooking of food. Yes No Comment _____*Toileting* — means both getting on and off the toilet and maintaining a reasonable level of personal hygiene. Yes No Comment _____*Transferring* — moving from a bed to a wheelchair or other type of convenience or furniture and returning to bed, as needed. Yes No Comment _____**Mental Status**Does the patient suffer from a cognitive impairment making him or her unable to think, perceive, reason or remember? Yes No Comment _____Is the patient mentally competent to understand ordinary business transactions and to receive proceeds of insurance? Yes No Comment _____Will current loss of functional capacity leave patient unable to perform two or more ADL's for 90 days? Yes No Comment _____Has patient had such a loss during the past 12 months? Yes No Comment _____**Patient Care Requirements**Nursing Home Confinement? Yes No Authorized Duration _____ To _____Hospice Confinement? Yes No Authorized Duration _____ To _____Adult Day Care? Yes No Authorized Duration _____ To _____Home Health Care? Yes No Authorized Duration _____ To _____Other (Specify)? Yes No Authorized Duration _____ To _____

Physician _____ T.I.N. or S.S.N. _____ Telephone _____

Address _____

Physician Signature _____ Date _____

PART 3**NURSING, HOSPICE, OR OTHER COVERED FACILITY'S STATEMENT**

(to be completed if benefits are claimed)

Date Admitted _____ Date Discharged _____ Total Days Confined _____

Total days out of facility during above period _____ Released To _____

Facility Name _____ Address _____

Signature _____ Telephone (_____) _____

Title _____ Date _____

PART 4**HOME HEALTH CARE AGENCY STATEMENT**

(to be completed if your policy provides these benefits and you are making a claim)

Days of Home Health Care provided _____ From _____ To _____ Days of Homemaker _____ From _____ To _____

Benefits Provided _____

Care Provided Assistance with bathing, dressing, feeding, toileting or transferring Shopping Occupational, respiratory, physical and speech therapy Housekeeping Nursing services requiring the services of a licensed nurse Transportation Constant supervision because a physician has determined that the patient has a cognitive impairment requiring such supervision Laundry Constant supervision because a physician has determined that the patient has a cognitive impairment requiring such supervision Cooking

Degree or Title of Person Providing Care _____ Days of respite care provided _____

Agency _____ From _____ To _____

Name _____ Street Address _____ City/State _____ Zip _____

Tax I.D. _____ State License No. _____ Federal Certification No. _____

Signature _____ Title _____ Date _____