everest®

We underwrite opportunity.

Sickness/Accident Medical Expense Claim Form and Instructions

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To Claimant:

As we know this is a difficult time, we want to assist you in filing your claim as quickly as possible. Please read the important instructions below regarding completing these claim form(s) in their entirety and accurately.

The information below constitutes a complete claim filed with Everest for purposes of claiming Accident or Sickness Medical Expense Benefits.

Instructions:

1. **Statement of Claim**, to be completed in its entirety.
    a. Provide any necessary and/or required attachments.
    b. Provide all required documents including, but not limited to, Receipts and Itemized/Standardized Bills (UB-04 forms for hospital charges and/or CMS-1500 forms for physician charges) Details of the Accident or Incident, and Police Reports if applicable.
    c. Please read the applicable Fraud Statement for your state of residence.
2. **Complete the Certification section**
3. Submit **claim form, itemized medical bill(s)** and **supporting documentation** via mail or email (as provided below).

Helpful Information for submitting claims and expediting payment

- A fully completed Claim Form is required for each accident/injury or sickness a Claimant incurs. Submitting incomplete information will delay the processing of your claim.
- Keep copies of all documentation for your records.
- Providers may wish to bill us directly for their services. If they do, please ensure a Claim Form has first been submitted to our office.
- Itemized medical bills (including claimant name, date(s) of service, diagnosis, procedure code(s), amount charged, and provider information) should be submitted for processing. Accordingly, we recommend providers submit standardized billing statements, specifically, UB-04 forms for hospital charges and/or CMS-1500 forms for physician charges.

Please detach this page and forward the completed Claim Form and supporting documentation to the address listed below. We recommend you retain copies of the items you have submitted for future reference.

Submit claim to: **Co-Ordinated Benefit Plans**
Mailing Address: **PO Box 20874, Tampa, FL 33622**
Email: **EverestClaims@cbpinsure.com**

Release of claim forms is not an admission of coverage under a policy for a policyholder, group, or organization.

PLEASE ENSURE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED

STATEMENT of CLAIM

A. Policyholder Information

Policy Number: **AHP 1200036-242**

Policyholder Name: **CHOWAN UNIVERSITY**

B. Claimant Information

Claimant Name:

Claimant Date of Birth: Click here to enter text. (Month / Day / Year)

Claimant Address: Click here to enter text. (Street, City, State, Zip Code)

Phone Numbers: Daytime: Click here to enter #. Evening: Click here to enter #. Personal Cell: Click here to enter #.

Email Address: Click here to enter text.

May we have your authorization to leave confidential medical and benefit information on your personal cell phone? And/or request this by E-mail? ☐ Yes ☐ No

C. Claim Information

Medical Expense Benefits claimed due to: ☐ Accidental Injury ☐ Sickness

For Claims due to Injury, please complete the following:

Date of Accident (Month / Day / Year): Click here to enter text.

Nature of Injuries: Click here to enter text.

Place of Accident: Click here to enter text.

Full Description/Details of the Accident (attach additional notes if necessary):
Click here to enter text.

For Claims due to Illness/sickness, please complete the following:

Date Illness/sickness first commenced (Month / Day / Year): Click here to enter text.

Full Description/Details of the Illness/Sickness (attach additional notes if necessary):
Click here to enter text.

CERTIFICATION

I certify that the above information furnished by me on the Statement of Claim is true and accurate to the best of my knowledge. I further certify I have read the fraud statements below and understand the laws of my state of residence. I also authorize any physician/hospital that has attended me or my dependent to disclose information acquired for claim payment purposes.

Acknowledge your electronic acceptance by checking the box below:

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document.

Name of Claimant: Click here to enter text.

Date (Month / Day / Year): Click here to enter text.

FRAUD STATEMENTS

APPLICABLE IN ALABAMA, ARKANSAS, MARYLAND, NEW MEXICO, TEXAS, and WEST VIRGINIA
Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to (civil)** fines and (criminal penalties)** confinement in prison. *Applies in MD only. ** Applies in NM only.

APPLICABLE IN ALASKA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, KENTUCKY, LOUISIANA, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW JERSEY, NORTH DAKOTA, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, UTAH, WISCONSIN, and WYOMING
Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and civil penalties and/or imprisonment.

APPLICABLE IN ARIZONA
For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

APPLICABLE IN CALIFORNIA
General: For your protection California law requires the following to appear on this form.
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

APPLICABLE IN COLORADO
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN DISTRICT OF COLUMBIA
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

APPLICABLE IN DELAWARE
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN FLORIDA
General: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

APPLICABLE IN HAWAII
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

APPLICABLE IN LOUISIANA
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICABLE IN MAINE
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 denial of insurance benefits.

APPLICABLE IN NEW HAMPSHIRE
Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

APPLICABLE IN NEW YORK
General: 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.

APPLICABLE IN NORTH CAROLINA
Any person who knowingly presents false information in an application for insurance or viatical settlement contract or a viatical settlement purchase agreement is guilty of a felony and may be subject to fines and confinement in prison.

APPLICABLE IN OHIO
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 guilty of insurance fraud.

APPLICABLE IN OKLAHOMA
General: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN OREGON
Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application or by filing a claim containing a misstatement, misrepresentation, omission, or false statement as to any material fact may be committing a fraudulent insurance act, which may be a crime and subject the person to criminal and civil penalties.

APPLICABLE IN PENNSYLVANIA
General: 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.

APPLICABLE IN PUERTO RICO
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON
General: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.