Catlin Insurance Company, Inc.

CRITICAL ILLNESS CLAIM

Administered by NBFSA, LLC
a Third Party Administrator

Claimant's Statement

(Please print – Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name____ **Date of Birth** _____/_____/_____

Insured's Social Security Number_________________________________ **Gender** ☐ **Male** ☐ **Female**

Insured's Address ____

Policy Number GAH-8000008-0415__________ **Phone Number** __________________________ **Social Security Number** _________________

CLAIM INFORMATION

Specify which Critical Illness you are claiming:

☐ Alzheimer's Disease
☐ ALS
☐ Benign Brain Tumor
☐ Blindness
☐ Cancer
☐ Carcinoma in Situ
☐ Coma
☐ Coronary Artery Bypass
☐ Deafness
☐ Kidney Failure (ESRD)
☐ Heart Attack
☐ Infectious Disease
☐ Major Organ Failure
☐ Multiple Sclerosis
☐ Occupational HIV
☐ Parkinson's Disease
☐ Permanent Paralysis
☐ Skin Cancer
☐ Stroke
☐ Other

Additional Child Diseases:

☐ Cerebral Palsy
☐ Congenital Birth Defect(s)
☐ Cystic Fibrosis
☐ Down Syndrome

Describe condition or illness:____

Date first seen for this condition _____/_____/_____ **Confirmed Diagnosis Date** _____/_____/_____

Have you been treated for a same or similar condition in the past? ☐ **Yes** ☐ **No If Yes, when?** ______________________________

Have you been hospitalized for this condition? ☐ **Yes** ☐ **No If Yes, list:**

First hospitalization related to this Critical Illness:

Hospital Name, City ______________________________________ **Phone** ____

Dates confined ____ **Attending Physician Name** _____________________________

Most recent hospitalization related to this Critical Illness:

Hospital Name, City ______________________________________ **Phone** ____

Dates confined ____ **Attending Physician Name** _____________________________

CLAIMANT INFORMATION

Claimant Name, if different than insured ____ **Date of Birth** _____/_____/_____

Relationship to Insured (spouse, dependent, other) ____________________________________ **Gender** ☐ **Male** ☐ **Female**

Claimant Address, if different than Insured ____

In what capacity are you making this claim? _____**Insured** _____**Claimant** _____**Beneficiary** _____**Guardian*** _____**Assignee*** _____**Other**

***Please provide a certified copy of all documents supporting your authority (e.g., Letters of Administration, Guardianship, Power or Attorney, etc.)**

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by Catlin Insurance Company, Inc. Insurance Trust, NBFSA, LLC, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud under any state and/or federal law having jurisdiction.

SIGNED (Insured or authorized person) ____ **DATE** ____/____/____

RETURN COMPLETED, SIGNED & DATED FORM ALONG WITH SUPPORTING DOCUMENTATION TO:

NBFSA, LLC
PO BOX 24279
WINSTON-SALEM NC 27114