



**DISABILITY CLAIM FORM**

**MAIL FORM TO**  
Pan-American Life Insurance Company  
P.O. Box 61070  
New Orleans, LA 70160-1070  
1-877-569-3075

**EMPLOYEE:** PLEASE FILL OUT THE EMPLOYEE PORTION OF THIS CLAIM STATEMENT. SIGN WHERE INDICATED TO AUTHORIZE RELEASE OF MEDICAL INFORMATION. (IMPORTANT - FAILURE TO FULLY ANSWER ALL QUESTIONS MAY DELAY PROCESSING OF YOUR CLAIM.) THIS FORM MUST BE ACCOMPANIED BY PROOF OF DISABILITY SIGNED BY THE ATTENDING PHYSICIAN. PROMPTLY RETURN THE COMPLETED FORMS TO YOUR EMPLOYER. **PLEASE PRINT.**

EMPLOYEE'S NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	SOC. SEC. NO./I.D. NO.	
EMPLOYEE'S STREET ADDRESS			CITY, STATE, ZIP		TELEPHONE
EMPLOYEE'S OCCUPATION		NAME OF PLANT OR BRANCH WHERE YOU WORK		ARE YOU MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DATE DISABLED AND UNABLE TO WORK	DATE TREATED FOR ILLNESS OR INJURY	NAME AND ADDRESS OF DOCTOR		IS CONDITION DUE TO AN OCCUPATION INJURY OR DISEASE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS CONDITION DUE TO AN INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF INJURY	WHERE DID IT OCCUR?			
DO YOU WISH TO HAVE FEDERAL INCOME TAX WITHHELD? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW MUCH _____					

DESCRIBE HOW ACCIDENT HAPPENED?

THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. ANY INFORMATION THAT MUST BE REQUIRED TO ESTABLISH THE VALIDITY OF ANY CLAIM FOR BENEFITS ON MY BEHALF MAY BE RELEASED TO AND USED BY EITHER MY EMPLOYER OR PAN-AMERICAN LIFE INSURANCE COMPANY ACTING ON BEHALF OF MY EMPLOYER, AND SAID ORGANIZATION AND PERSONS MAY DISCLOSE ANY PERSONAL OR CLAIM INFORMATION NEEDED FOR CASE REVIEW AND STUDY. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

\_\_\_\_\_  
SIGNATURE OF EMPLOYEE

\_\_\_\_\_  
DATE

**EMPLOYER:** PLEASE FILL IN YOUR NAME AND ADDRESS ON THIRD LINE BELOW TO ASSURE PROPER RETURN OF THIS FORM. AFTER THE EMPLOYEE AND DOCTOR STATEMENTS HAVE BEEN COMPLETED, PLEASE CERTIFY EMPLOYEE'S CURRENT EMPLOYMENT STATUS BY FILLING OUT AND SIGNING THE EMPLOYER PORTION OF THIS FORM.

DATE LAST WORKED	NUMBER OF HOURS	DATE EXPECTED TO RETURN	DATE RETURNED	EMPLOYEE'S CURRENT WKLY EARNING \$	WEEKLY A&S RATE \$
DATE EMPLOYED	EFFECTIVE COVERAGE DATE APPLICABLE TO CLAIM		DATE COVERAGE TERMINATED	CLASS OF INSURANCE	IS CONDITION DUE TO EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME AND ADDRESS OF EMPLOYER				CONTROL NUMBER	
DATE	SIGNATURE (EMPLOYER)			TITLE	

IS THIS A CONTRIBUTORY PLAN?  YES  NO IF SO, WHAT %?

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PRUPOSE 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.

# HEALTH PLAN CLAIM

Dear Doctor: After you have completed and signed this form, please return it to YOUR PATIENT'S EMPLOYER as soon as possible.

<b>PATIENT &amp; EMPLOYEE INFORMATION</b>						
1. PATIENT'S NAME (First name, middle initial, last name)		2. PATIENT'S DATE OF BIRTH		3. EMPLOYEE'S NAME (First name, middle initial, last name)		
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)		5. PATIENT'S SEX		6. EMPLOYEE'S I.D. OR MEDICARE NO. (Includes any letters)		
9. OTHER HEALTH INSURANCE COVERAGE- Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number.		7. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER		8. EMPLOYEES GROUP NO. (Or Group Name)		
10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>		11. EMPLOYEE'S ADDRESS (Street, city, state, ZIP code)				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <small>I authorize the Release of an Medical Information Necessary to Process this Claim and Request Payment of MEDICARE CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below</small>			13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW			
SIGNED _____		DATE _____		SIGNED (Insured or Authorized Person) _____		
<b>PHYSICIAN OR SUPPLIER INFORMATION</b>						
14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		15. DATE FIRST CONSULTED YOU FOR THIS CONDITION		16. HAS PATIENT EVER HAD THE SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
17. DATE PATIENT ABLE TO RETURN TO WORK		18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____		
19. NAME OF REFERRING PHYSICIAN				22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES _____		
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)						
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. <u>RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC OR DX CODE</u>						
1. _____						
2. _____						
3. _____						
4. _____						
24.	A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY: _____) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F
25. SIGNATURE OF PHYSICIAN OR SUPPLIER			26. ACCEPT ASSIGNMENT YES <input type="checkbox"/> NO <input type="checkbox"/>		27. TOTAL CHARGE	
SIGNED _____ DATE _____			30. YOUR SOCIAL SECURITY NO. <b>MUST BE FURNISHED UNDER AUTHORITY OF LAW.</b>		28. AMOUNT PAID	
32. YOUR PATIENT'S ACCOUNT NO.			31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		29. BALANCE DUE	
			33. YOUR EMPLOYER I.D. NO.			
			I.D. NO.			

\* PLACE OF SERVICE CODES

1-(IH) - INPATIENT HOSPITAL  
2-(OH) - OUTPATIENT HOSPITAL  
3-(O) - DOCTOR'S OFFICE

4-(H) - PATIENT'S HOME  
5- DAY CARE FACILITY (PSY)  
6 - NIGHT CARE FACILITY (PSY)

7-(NH) - NURSING HOME  
8-(SNF) - SKILLED NURSING FACILITY  
9- AMBULANCE

0-(OL) - OTHER LOCATIONS  
A-(IL)-INDEPENDENT LABORATORY  
B- OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

## NOTICE CONCERNING YOUR RIGHTS OF PRIVACY AS A CONSUMER

Pan-American Life Insurance Company collects nonpublic information about you from the following sources:

- Information we receive from you in applications or other forms;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer reporting agency.

We do not disclose any nonpublic information about our customers or former customers to anyone, except as permitted by law.

We restrict access to your nonpublic personal information to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.