CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427
Columbia, South Carolina 29202

CLAIM FORM

Email: CSC@caig-ins.com
Phone (800)433-3036 Fax (803)799-7737

Supplemental Hospital and Medical Indemnity Claim Instructions

1. Please complete sections 1 through 6.
2. Read and sign the Authorization, section 7. The authorization will be used in obtaining information needed to process your claim. Failure to complete the Authorization will result in a delay in processing.
3. If your loss is the result of an Accident, please provide a complete description of your accident. If the accident was a motor vehicle accident attach a copy of the police or accident report. If you were injured in an on-job or occupational injury, attach a copy of the first report of injury filed with your employer.
4. If you were first treated at an emergency room, please attach a copy of the discharge papers from the hospital in order for us to verify the first date of treatment.
5. Please attach a copy of all bills and supporting documents related to the treatment of your loss. The medical bills and supporting documents should include the diagnosis, the specific procedure or treatment the covered insured received, the date of service, and the amount charged for physician services, emergency room treatment and supplies. If you are filing for hospital confinement benefits, attach a copy of the itemized hospital bill showing the number of days of hospitalization or an admission and discharge summary.
6. If you are filing during the first year of your coverage effective date and subject to a pre-existing investigation, complete the enclosed pre-existing statement form in full and return to our office with your claim form.

PART A — POLICYHOLDER/CLAIMANT'S STATEMENT

1

POLICYHOLDER'S NAME	POLICY/CERTIFICATE NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX

2

POLICYHOLDER'S ADDRESS	STREET	CITY	STATE	ZIP CODE

3

CLAIMANT'S NAME (PERSON WHO IS SICK OR INJURED)	DATE OF BIRTH	RELATIONSHIP TO POLICYHOLDER	POLICYHOLDER'S TELEPHONE NO. (INCLUDE AREA CODE)

4 DESCRIBE WHEN AND HOW YOUR ACCIDENT OCCURRED OR THE ONSET AND NATURE OF YOUR ILLNESS.

5

IS YOUR ACCIDENT OR SICKNESS RELATED TO YOUR OCCUPATION
☐ NO ☐ YES

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED?
☐ NO
☐ YES — STATUS: ☐ APPROVED ☐ PENDING ☐ DENIED

6

DATE SYMPTOMS FIRST APPEARED

DOCTOR TREATED OR REFERRED BY WITHIN THE LAST YEAR:

DATE	NAME	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.

IF HOSPITALIZED WITHIN THE LAST YEAR:

DATE	NAME	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.

AUTHORIZATION

7

Several states require that the following statement appear on the claim forms:

Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.

I have checked the answers given by myself and they are correct. I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment and any non-medical information of me, to give to Continental American Insurance Company or its legal representative, any and all such information. This Information is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug or alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or other sexually transmitted diseases, including case history and medical antecedents. I UNDERSTAND the information obtained by use of the Authorization will be used by Continental American Insurance Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by Continental American Insurance Company to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE that this Authorization shall be valid for the duration of my claim.

Policyholder's Signature: Date: Claimant's Signature: Date: