ESIS®

Critical Illness Claim Form

IMPORTANT NOTICE: This claim form is to facilitate your claim in the event of you or a member of your family is confined to hospital while being insured under a Personal Accident policy.

Please mail your completed Claim Form along with the items listed below to:

ESIS Specialty Claims
PO Box 6802
Scranton, PA 18505-0556

(844) 756 5571 Inside USA
(248) 368 0577 Outside USA
(248) 440 7626 Fax
ESISA&H@esis.com

In addition to the Claim Form, the following items are required:

1. Attach an Attending Physician's Report detailing the nature of the illness. The report needs to
2. Please note that you or the claimant is responsible for any expenses incurred in obtaining
3. The issue and acceptance of this form and its accompanying documents (if any) does NOT

Section A: Particulars of Policyholder / Insured Person

Policyholder Name: _____ Policy Number(s): _____

Facts concerning insured

First Name: _____ Last Name: _____

SSN: _____

Email Address: _____ Cell Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

County: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Employer Information for Policyholder/Insured Person

Name of Employer: _____

Occupation: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Facts concerning claimant (if different from insured)

First Name: _____ Last Name: _____

SSN: _____

Email Address: _____ Cell Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

County: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Employer Information for Policyholder/Insured Person

Name of Employer: _____

Occupation: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Section B: Details of Claim

Date of symptoms first noticed (DD/MM/YYYY): _____

Date of first consultation with a medical practitioner for this condition (DD/MM/YYYY): _____

Nature of Illness. Describe the symptoms suffered:

_____

_____

_____

Has the claimant ever seen a doctor for any similar condition in the past? ☐Yes ☐No

If **Yes**, please provide details:

_____

_____

_____

Name of Clinic / Hospital (if multiple, document all facilities):

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Name of Attending Physician: _____

Phone Number: _____ Fax Number: _____

Period of Hospitalization

From (DD/MM/YYYY) _____ To (DD/MM/YYYY) _____

If claimant is/was hospitalized outside of the United States, please advise:

Claimant's Address When Overseas:

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Purpose of Overseas Trip: _____

Duration of Overseas Trip:_____ days

Section C: Other Insurance Coverage

Are you claiming from any other inraunce company or other sources with respect to this condition:

☐Yes ☐No

If **Yes**, please provide details below (Please use supplementary sheet if necessary):

Name of Insurance Company	Policy No.	Amount of Benefits	Date Insurance Effected

Section D: General Details

Have any of of your blood relatives sufferd from a similar condition or related illness? ☐Yes ☐No

If **Yes**, please provide the details:

Relationship of Kin	Nature of Illness	Date of Diagnosis

Section E: Declaration

Did you remember to enclose the following? (Where applicable)

Document	Yes	NA
Written notes from Physician on type of injury sustained / Inpatient Discharge Summary or Medical Report	☐	☐
Original Medical Bills	☐	☐
Copy of Medical Certificates	☐	☐

By signing this form, I / We agree that ESIS will use the information supplied here and during the formation and performance of this policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that ESIS may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I / We hereby authorize any hospital, physician, and any other person or entity who has attended to or examined the Insured, to furnish to ESIS or its authorized representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as ESIS in its absolute discretion considers relevant for its assessment of this claim. A photo static copy of this authorization shall be considered as effective and valid as the original.

I / We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I/We agree that if I / We have made or in any further declaration or representation shall make any false or fraudulent statements or suppress, conceal or falsely state any fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims shall be forfeited.

Signature of Claimant

Signature of Insured Person (if different from Claimant)

Date

Fraud Warning: Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. We have adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic 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.

The following states have required us to use state specific language as follows:

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

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.

Florida
Any person who knowingly and with intent in injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York
Any person who knowingly and with 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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

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

Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maryland/Oregon
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 may be guilty of insurance fraud.

Virginia
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 may have violated state law.