

## Hospital Income Plan 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 Hospital Income policy.

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

ESIS Specialty Claims (844) 756 5571 Inside USA  
PO Box 6802 (248) 368 0577 Outside USA  
Scranton, PA 18505-0556 (248) 440 7626 Fax  
ESIS&H@esis.com

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

1. If you are claiming for Recuperation / Post Hospitalization benefits, please attach detailed Pre Medical / Final Hospitalization/Post Medical Report or a copy of the Inpatient Discharge Summary to the Claim Form.
2. If you are claiming for Medical / Hospital expenses, please attach the original detailed Final Bills and Receipts.
3. The issue and acceptance of this form does NOT constitute an admission of liability by ESIS.

### Section A: Particulars of Policyholder / Insured Person

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Policyholder Name \_\_\_\_\_ Policy Number(s): \_\_\_\_\_

#### Facts concerning insured

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

Address Line2: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

ZIP: \_\_\_\_\_ Country: \_\_\_\_\_

County: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female

#### Employer Information

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

Relationship to the insured: \_\_\_\_\_

*Employer Information*

Name of Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Street Address: \_\_\_\_\_

Address Line2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

ZIP: \_\_\_\_\_ Country: \_\_\_\_\_

**Section B: Details of Claim**

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Name of Hospital \_\_\_\_\_

Period of Hospitalization From (DD/MM/YYYY) \_\_\_\_\_ To (DD/MM/YYYY) \_\_\_\_\_

Was the Insured referred by a General Practitioner / Specialist / Other Hospital?  Yes  NoIf **Yes**, please provide details below:

Name of General Practitioner / Specialist / Hospital \_\_\_\_\_

Street Address: \_\_\_\_\_

Address Line2: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

ZIP: \_\_\_\_\_ Country: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Please complete this portion of hospitalization was due to an accident.

*Details of the Medical Practitioner who is currently treating the insured*

Name of Clinic/Hospital: \_\_\_\_\_ Name of Doctor: \_\_\_\_\_

Street Address: \_\_\_\_\_

Address Line2: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

ZIP: \_\_\_\_\_ Country: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Date of the accident (DD/MM/YYYY): \_\_\_\_\_

Time of the Accident (24-hour HH:MM): \_\_\_\_\_

Place of Accident (Country, State/Province): \_\_\_\_\_

Who discovered the accident and when: \_\_\_\_\_

Relationship of this person to the insured: \_\_\_\_\_

### **Witness Information**

Were there witnesses to the accident?  Yes  No

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

#### **Witness 1**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

Address Line2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

ZIP: \_\_\_\_\_ Country: \_\_\_\_\_

#### **Witness 2**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

Address Line2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

ZIP: \_\_\_\_\_ Country: \_\_\_\_\_

Was the Insured under the influence of alcohol, medication, drugs or any other intoxicating substance at the time of accident? Yes No

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

Name / Type of Alcohol, Medication, Drugs or Intoxicating Substances	Quantity Consumed	Date and Time Consumed

Nature of Injury (e.g., fracture, cut, bruises, etc.): \_\_\_\_\_

Chronology and description of the accident (Please use supplementary sheet if necessary):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please complete this portion if hospitalization was due to an illness

*Details of the Medical Practitioner who is currently treating the insured*

Name of Clinic/Hospital: \_\_\_\_\_ Name of Doctor: \_\_\_\_\_

Street Address: \_\_\_\_\_

Address Line2: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

ZIP: \_\_\_\_\_ Country: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Naure of Illness (describe the symptoms suffered):

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

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

Describe the symptoms presented during the first consultation:

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

If **Yes**, please provide details:

Name of Clinic/Hospital: \_\_\_\_\_ Name of Doctor: \_\_\_\_\_

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): \_\_\_\_\_

## **Section C: Any Other Claims / Insurance**

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Have you claimed or are there any other insurance policies that cover or may provide cover for hospitalization, whether for this incident or in the past?    Yes    No

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

Name of Insurance Company	Policy No.	Type of Policy	Date Policy In Effect

## **Section D: Declaration**

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

Document	Yes	NA
Traffic Police Report (if involved in a Road Accident)	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Final Hospital Bill	<input type="checkbox"/>	<input type="checkbox"/>
Written notes from Physician on type of injury sustained/Inpatient Discharge Summary or Medical Report	<input type="checkbox"/>	<input type="checkbox"/>

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.

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Signature of Claimant

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Signature of Insured Person (if different from Claimant)

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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 to 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 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 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 any 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.