



HOSPITAL INDEMNITY CLAIM REPORT

When Completed, Please Send To: **Associated Mutual Insurance**

3809 Lake Eastbrook Blvd SE, Grand Rapids, MI 49546

Phone: (888) 808-0408

Fax: (616) 726-1252

SECTION A CLAIMANT'S STATEMENT			
Name of Insured		Social Security Number	Date of Birth
Home Address		Telephone	Name of Patient, if Different
City	State	Zip	Relationship
Date Accident or Sickness Began		Date of Birth	Sex
Date Accident or Sickness Began		Nature of Sickness or Injury	
If Injured, How and Where did accident happen?			
If Illness, When were you first troubled with this disease?		When did you first obtain treatment?	
Have you ever had the same or a similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when?			
Names and Addresses of all physicians consulted for this condition			
Name	Street Address	City and State	Zip
Names and Address of Hospital			
Name	Street Address	Confinement Dates	
IMPORTANT: ATTACH COPY OF HOSPITAL BILL TO THIS FORM			
I understand and acknowledge that any hospital, physician, or other person who has attended or examined me may furnish to Associated Mutual Insurance, Inc. or its representative, any and all information concerning any illness or injury I may have suffered, medical history, consultations, prescriptions, or treatments, included X-rays and copies of all hospital or medical records. Associated Mutual Insurance may also release information contained in its files to its reinsurers including the information obtained hereby. A copy of this acknowledgement shall be considered as effective and valid as the original.			
Patient's Signature (Parent, if minor)			Date
			Completed
SECTION B ATTENDING PHYSICIAN'S STATEMENT			
THIS PORTION MUST BE COMPLETED BEFORE CLAIM CAN BE PROCESSED.			
Patient's Name		Age	Dates of Hospital Confinement
Nature of Sickness or Injury - (Describe complications, if any)			
When did symptoms first appear or accident happen?		When did patient first consult you for this condition?	
Describe any other disease or infirmity affecting present condition			
Has patient ever had same or related condition? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, state when and describe			
Is Confinement due to pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Conception	Name and Address of referring physician
GIVE DATES OF TREATMENTS	Office		
	Hospital		
Signature of Attending Physician		Date Signed	ID #
		Street Address	City/State
			Zip

SECTION C**EMPLOYER'S OR ADMINISTRATOR'S STATEMENT****THIS PORTION MUST BE COMPLETED BEFORE CLAIM CAN BE PROCESSED.**

Name of Employee		Occupation	
Social Security Number		Date Employed	Date Insured
Date Last Worked	Return to work <input type="checkbox"/> Yes <input type="checkbox"/> No If so, date		Benefit Amount
Has Insured's employment terminated? If so, when? Reason			
Do you recommend payment of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain			
Employer		Telephone #	
Address			
By	Title		Date

