KEMPER Health

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY

P.O. Box 9988, Austin, TX 78766-9988
Telephone: 844.613.6245 Fax: 844.473.8084
Email: Service@kemperbenefits.com Website: kemperbenefits.com

ACCIDENT CLAIM FORM
(WITH DISABILITY INCOME RIDER)

Instructions to File a Claim:

- Please provide all bills associated with your claim, including treatment dates, total charges, diagnoses and procedure codes and/or itemized bills: HCFA 1500 or UB-92.
- If your accident is due to a motor vehicle collision, we will require a copy of the police report for all motor vehicle accident claims and any other incidents investigated by any law enforcement agency.
- If death was a result of the accident, please include a certified copy of the death certificate for the deceased.
- In order to document the contents of this form, the Insured must sign and date the completed claim form.
- If you are filing for disability, please have your employer complete the Employer's Statement and your doctor complete the Attending Physician's Statement.

Insured/Claimant Statement

Insured's Name (Last, First, Middle)	Policy/Certificate #	Social Security No.	Date of Birth	Sex
Address (Street, City, State, Zip)				
Phone Number (With Area Code)		Email Address		
Claimant's Name (Person who is injured)	Date of Birth	Relationship to Insured		
1. Date of Accident:	2. Date of Initial Treatment:	3. If auto accident please circle: Driver Passenger Unknown		
4. Describe how and where it happened:				
5. Is your accident related to your occupation? Yes No 6. Is your accident covered by Worker's Compensation? Yes No Pending				

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO RESERVE NATIONAL INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINIAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE____________________ INSURED'SIGNATURE: ____________________

DATE____________________ CLAIMANT'S SIGNATURE: ____________________

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Attending Physician Statement (*Must be completed by physician or physician's staff*)

Diagnosis (Please give ICD-9 code)	Date of Onset:	Date First Consulted:	Surgical Procedures:
Additional Diagnoses:		Date of Surgery:	
Total Disability: From: __________________ To:_________________ Partial Disability: From: __________________ To:_________________		Date of Return to Work:	

Physician's Name (Please print)_______________________________________ Date _________________________________

Physician's Signature____ TIN/SSN________________________________

Address ____ Phone__________________ Fax_________________

City____State__________________________Zip__________________

Employer's Statement (*Must be completed by employer*)

Employer's Name____

Address ____ Phone ______________________________

Work Status:

1. Is disability caused by an accident that occurred at the workplace? Yes No
2. Prior to this disability, number of hours worked per week ______________________________
3. Is the person still employed? Yes No If no, date person left employment_______________________
4. First date employee unable to work______________________
5. Last date employee unable to work______________________
6. Is employee currently working? Yes No
7. If yes, is employee working? Full-time Part-time Light-duty
8. Date of return to work________________________

Premium/Tax Information: (The employer is required to report disability benefits paid on pre-tax plans on its Form 941 and the employee's Form W-2.)

1. Does the employee pay disability premiums with pre-tax dollars? Yes No
2. Does the employer pay a portion of the disability premium for the employee? Yes No

Employer's Signature____Title__________________________Date_____________