



Insurance Company of North America
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ace insurance

ACCIDENT AND SICKNESS PROOF OF LOSS FORM

NOTICE TO INSURED-CLAIMANT:

Please answer all questions completely and accurately. Indicate N.A., where question is not applicable.

To enable us to process your claim promptly, please attach the following documents indicated with "✓" mark:

- | | | |
|---|---|----------------------|
| <input type="checkbox"/> Hospital Income Plans | Hospital Statement of Account | OR for Surgeon's Fee |
| <input type="checkbox"/> Hospital Discharge Summary and Admitting History | Original Bills & Receipts | |
| <input type="checkbox"/> Accident Protection Plans | Police Report &/or Accident Report | |
| A. Medical Reimbursement | Certified Copy of Operating Room Record | |
| B. Dismemberment Claims | Birth & Death Certificate, Autopsy Report, Police Report, Affidavit of Witness, | |
| C. Death Claims | Photograph/Newspaper Clipping, Proof of Relationship to Beneficiary | |
- You will be notified in case additional documents are required.
 The Company makes no admission of liability or waiver of rights by furnishing this form.

PART A TO BE COMPLETED BY INSURED

FULL NAME OF INSURED	NAME OF CLAIMANT:	DATE OF BIRTH	HEIGHT	WEIGHT
CLAIM IS FOR <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD				
POLICY NUMBER/CERTIFICATE				
IF GROUP POLICY, GIVE NAME OF GROUP				
GIVE EMPLOYER'S NAME AND ADDRESS				
WHEN WERE YOU OR CLAIMANT INJURED OR BECAME SICK?	DATE	20__	AT	____ P.M. ____ A.M.
IF INJURED, DESCRIBE FULLY HOW AND WHERE ACCIDENT OCCURRED				
WHAT IS YOUR PHYSICIAN'S OR SURGEON'S NAME AND ADDRESS?	NAME OF OTHER PHYSICIAN CONSULTED PRIOR TO CONFINEMENT			
IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL	ADDRESS:			
HOSPITAL CONFINEMENT	FROM	20__	AT	____ P.M. ____ A.M.
				TO
				20__
COMPLETE BELOW FOR DISABILITY BENEFITS ONLY - IN ANY EVENT, PLEASE SIGN BELOW				
DESCRIBE FULLY THE DUTIES OF YOUR OCCUPATION				
WHEN DID YOU CEASE WORK?	DATE	20__	AT	____ P.M. ____ A.M.
IF ILLNESS, HOUSE CONFINEMENT FROM	DATE	20__	TO	____ 20__
WHEN DID, OR WILL, YOU RESUME ANY PART OF YOUR WORK?	DATE	20__	AT	____ P.M. ____ A.M.
ALL WORK?	DATE	20__	AT	____ P.M. ____ A.M.
ARE YOU INSURED FOR DISABILITY IN ANY OTHER ORGANIZATION?	NAME OF COMPANIES AND STATE AMOUNT OF BENEFITS			

ADDRESS _____ SIGNATURE _____

TEL. NO. _____ DATE _____

PART B**ATTENDING PHYSICIAN'S STATEMENT**

1. PATIENT'S NAME _____

DATE OF BIRTH/AGE _____

2. DIAGNOSIS AND CONCURRENT CONDITIONS: _____

CONFINED FROM _____ TO _____

3. COMPLETE ADMITTING HISTORY: _____

4. PAST MEDICAL HISTORY: _____

5. PERTINENT PHYSICAL EXAMINATION FINDINGS: _____

6. SIGNIFICANT DIAGNOSTIC PROCEDURE FINDINGS: _____

7. REPORT OF SERVICES

Date of Services _____ Place of Services _____

Description of Surgical or Medical Services Rendered/Procedure _____

8. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? _____

PREGNANCY? _____

If Yes, Approximate Date Pregnancy Commenced. _____

9. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED: _____

Yes No Yes No

Date _____

DATE CONDITION WAS DIAGNOSED: _____

11. PATIENT EVER HAD SAME OR SIMILAR CONDITION? _____

Yes No If "Yes" When and Describe: _____

12. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? _____

Yes No

13. WERE REGISTERED PRIVATE DUTY NURSE (R.N.) SERVICES NECESSARY? _____

Yes No

15. PATIENT WAS PARTIALLY DISABLED. _____

14. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED

From _____ Thru _____

17. PATIENT WAS HOUSE CONFINED. _____

From _____ Thru _____

16. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK. _____

From _____ Thru _____

DATE _____ PHYSICIAN'S NAME (PRINT) _____

SIGNATURE _____

LICENSE NO _____

ADDRESS _____

TELEPHONE _____

PARTIAL DISABLEMENT arises when the Claimant is only slightly injured or has so far recovered from injuries as to be capable of attending to some portion of his ordinary profession, business or occupation.

"Permanent Total Disability means disablement which, having lasted for at least 12 consecutive months, will, in all probability, entirely prevent the insured person from engaging in gainful employment of any and every kind for the remainder of his or her life."

MEDICAL INFORMATION AUTHORIZATION

To: Medical Record Section _____

Hospital _____

I hereby authorize any hospital, physician, or other person who attended me or examined me, to disclose when requested to do so by the Insurance Company of North America, or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.
You are hereby released from all legal liability that may arise from the release of the information requested.

APPROVED BY: _____

SIGNATURE (Attending Physician) _____

M.D.

PATIENT'S/CLAIMANT'S SIGNATURE: _____

DATE: _____

FAILURE TO COMPLETE THIS FORM MAY DELAY PROCESSING/PAYMENT OF YOUR CLAIM.