NATIONWIDE LIFE INSURANCE COMPANY
NATIONAL CASUALTY COMPANY
– SEE INSTRUCTIONS –

Claim Form **SPECIALTY HEALTH CLAIM FORM (please print or type)** GROUP INSURANCE

SECTION I TO BE COMPLETED IN FULL BY THE PLAN SPONSOR ORGANIZATION Plan Sponsor Signature required ***(You may submit proof of membership or certificate of Coverage in place of Plan Sponsor signature)***

1. Policy Number _____ 2. Name of Plan Sponsor Organization _____ (Group's Name)

3. Name of Patient _____ 4. Sex ☐ M ☐ F 5. School Grade _____

6. Address of Patient _____ (Street) (City) (State) (Zip)

COMPLETE IF ACCIDENT IS INVOLVED

7. Date and Time of Accident: Date ___/___/_____ Time _____ ☐ AM ☐ PM
Dismemberment/Plegia ☐ Fatality ☐
8. **WHAT** injuries were received? _____
9. **WHERE** did the accident take place? _____
10. **HOW** did the accident take place? (Be specific, explain exactly what happened.)
_____
11. Did the accident occur:
a. ☐ While taking part in an activity **sponsored** and **directly supervised** by the plan sponsor.
Describe **type** of activity involved _____
Name of Supervisor _____ Title _____
Phone ( ) _____
b. ☐ During **direct** travel to or from the meeting place to take part in an Patient activity.

COMPLETE IF SICKNESS IS INVOLVED

12. Nature of sickness _____
13. Date symptom first appeared _____/_____/_____
14. Date of **first** expense resulting from the sickness _____/_____/_____

I certify that the above information is correct to the best of my knowledge and belief, that the person named in item 3 is insured by the policy, and that his or her insurance was in effect on the date the accident or sickness occurred. The signature cannot be by the Patient, a Patient's spouse, son, daughter, father, mother, brother or sister, other relative or agent.

15. Signature of Plan Sponsor _____ 16. Date _____/___/_____
17. Title _____ 18. Phone ( ) _____

SECTION II TO BE COMPLETED BY THE PATIENT (PARENT OR GUARDIAN IF MINOR)

19. Patient's Name _____ 20. Birth date ___/___/___ 21. Social Security No. _____/___/_____
22. Patient's Employer (Name and Address) _____
23. Spouse's Employer (Name and Address) _____
24. IF A MINOR – Parent's (Name and Address) _____
25. Father's Employer (Name and Address) _____
26. Mother's Employer (Name and Address) _____
27. Is the Patient covered by any of the above employer's health plan or by any other plan? ☐ Yes ☐ No If Yes, give the names of and addresses of the insurance companies or plans, show the types of plans (group, HMO, individual, etc.) and attach itemized copies of the expenses paid by them:

Basic Coverage with: _____ Type of Plan _____
Major Medical with: _____ Type of Plan _____
Other Coverage with: _____ Type of Plan _____

I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available regarding either: (a) benefits for which either I, or the minor child for whom I am either parent or guardian, may be entitled to for this claim, or (b) the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or the minor child for whom I am the parent or guardian; to give SPECIAL RISKS CLAIMS, Columbus Ohio, or it legal representatives, any and all such information. I AGREE that a photographic copy of this Authorization will be valid as the original. This authorization will remain valid for the term of coverage of the policy.

28. Date ___/___/____ 29. Signature of Patient X_____ 30. Phone ( )_____
(Parent or Guardian, if minor)

SECTION III ASSIGNMENT OF BENEFITS

I AUTHORIZE Special Risks Claims, Columbus Ohio, to pay benefits in connection with this claim directly to the doctor, hospital, or other supplier.

31. Date ___/___/____ 32. Signature of Patient (Parent or Guardian, if minor) _____

THIS CLAIM CANNOT BE PROCESSED WITHOUT ALL OF THE ABOVE INFORMATION AND STATEMENTS OF PAYMENTS FROM THE OTHER PLANS.

CLAIM FILING INSTRUCTIONS
NOTE TO ORGANIZATIONS AND PATIENT

Our objective at Special Risks Claims is to provide fast and accurate claims service. Listed below are some instructions on claim submissions that, when followed, will assist us in providing this service.

EXCESS COVERAGE

If the policy is an EXCESS PLAN, we will not pay benefits for, nor can the deductible (if any) be satisfied by, covered expenses to the extent that they are collectible under:

1.) **another insurance contract or prepayment plan;**
2.) **a trusteed, union, employer, or employee benefit plan;**
3.) **Workers' Compensation (or similar occupational law); or**
4.) **A government plan (except Medicaid and other public assistance plans), including one set forth by statute (such as Medicare)**

WHEN TO FILE A CLAIM

1. **If the policy contains an EXCESS MEDICAL EXPENSE BENEFIT, YOU MUST FIRST FILE THE CLAIM WITH ALL OTHER PLANS (including major medical) so we may determine what benefits are payable.**
2. **Written proof of loss (the completed claim form and supporting documents) should be given to us within 90 days after the loss starts.**

HOW TO FILE A CLAIM

1. **Have the plan sponsor complete and sign Section I of the claim form. Make sure all information is provided, including the plan sponsor name, policy number and information on how/when the accident or sickness occurred.**

2. **The Patient (parent or guardian, if minor) must complete Section II in full.**

   Completion of a claim form with false, incomplete or misleading information may be considered a criminal act, and because of the additional investigation time required, may result in processing delays. Before you submit a claim, please double check all of the information on the form to assure that it is accurate.

3. **If you want payment to be made directly to the provider or medical services, sign and date Section III.**

4. **File the medical claim(s) with the other insurer(s) as soon as possible. Upon receipt of the explanation of benefit statement(s) from your other insurance company(ies) or plan(s) showing payment or denial of claim, submit a copy of the statement(s) along with the completed claim form and copies of all itemized bills to us for processing. An itemized bill normally lists the patient's name, diagnosed condition, treatment dates and charge per treatment, and including the name, address, and federal tax identification number of the provider of service.**

HOW TO FILE A CLAIM Continued

5. If there is NO OTHER INSURANCE COVERAGE, obtain a written statement from the Patient's/Parent' employer(s) verifying that no other coverage exists. Complete Steps 1, 2, and 3 from HOW TO FILE A CLAIM above and mail with the itemized bills to us for processing.

6. Only one (1) completed claim form is required per accident or sickness. It is also essential that correspondence clearly identify the plan sponsor, policy number, and the patient's name.

WHERE TO FILE A CLAIM

Specialty Health Claims
PO BOX 420
Springfield, MA 01101
Phone: 1-800-525-8669
Web Address: GrouProtector.com

Nationwide®
On Your Side™

NATIONWIDE MUTUAL INSURANCE COMPANY
NATIONWIDE LIFE INSURANCE COMPANY
NATIONAL CASUALTY COMPANY

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Nationwide Life Insurance Company and Nationwide Mutual Insurance Company and National Casualty Company (collectively referred to as "Nationwide") are required by law to maintain the privacy of our members' health information. Unless you have signed a form authorizing the use or disclosure, we will not use or disclose your health information for any purpose other than Nationwide's role in treatment, payment or for health care operations. With your written approval, we may disclose your health information to others, including designated family, friends, or others who are involved in your health care or in payment for your health care. This form allows you to designate this/these person(s). A copy of this form is as valid as the original.

I understand that I am not required to sign this authorization form and that Nationwide will not condition coverage or the provision of payment to me on the signing of this authorization.

A SEPARATE FORM MUST BE COMPLETED FOR EACH ELIGIBLE PERSON. This form can be copied if additional forms are needed.

I, _____, hereby authorize the use or disclosure of health information about me as described below.
(Instructions for above: print eligible person's name if over age 17, or if age 17 or under, the eligible person's parent or personal representative.)

As parent or personal representative, I authorize the use or disclosure of health information about the eligible person who is age 17 and under, as described below.

1. Person(s) or group of persons authorized to disclose the information:

- Nationwide

2. Person(s) or group of persons authorized to receive and use the information from Nationwide.

Family and friends: check all that apply if you wish a family member or friend to be able to discuss your coverage and claims with Nationwide, and to receive health information which Nationwide maintains about you:

☐ Spouse (write in name and address): _____
_____

☐ Family member (write in name and address): _____
_____

Explain relationship: _____

☐Friend(s) or Other(s) (write in name and address): _____
_____

Explain relationship: _____

3.bDescription of the information that may be used or disclosed:

- All health information pertaining to me or my minor dependent(s) or the eligible person, if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition and any other policy related information.

4. I understand that if the person or entity that receives the information described herein is not a health care provider or health plan covered by federal privacy regulations, the information described here may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

5. If the person completing this authorization is the personal representative of the eligible person or dependent, describe your authority to act on this person's behalf.

_____

_____

6. As described in the Notice of Privacy Practices I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Nationwide in reliance on this authorization by sending a written signed and dated revocation to Special Risks, Nationwide, P0 Box 2399, Mail code CO-Ol-26, Columbus, OH 43216-2399. A copy of the Notice of Privacy Practices is also available upon request at this address.

7. I understand that either my personal representative or I may receive a copy of this authorization upon request and that I may inspect or copy the information to be used or disclosed.

8. This authorization will expire 36 months after the policy termination date.

Eligible Person Signature _____ Date: _____

Personal Representative Name, if applicable _____
(As described above in #5)

Personal Representative Signature _____ Date: _____

Return form to: Claims, PO Box 420, Springfield, MA 01101

State Fraud Notices

(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 MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

(Alaska) A person who knowingly and with intent to injury, defraud, or deceive an insurance company files a claim containing, false, incomplete, or misleading information may be prosecuted under state law.

(Arkansas) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Arizona) For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

(CALIFORNIA) FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM.
ANY PERSON WHO KNOWINGLY PRESENTS A 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. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

(DISTRICT OF COLUMBIA) 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 BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

(Delaware) Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

(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.

(Idaho) Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

(Indiana) A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

(Kentucky) 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.

(Louisiana) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Maine) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(Minnesota) A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

State Fraud Notices Continued

(New Hampshire) Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

(New Jersey) Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

(New Mexico) ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

(Ohio) 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 is guilty of insurance fraud.

(Oklahoma) WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds 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 an application for insurance or 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.

(Virginia) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."