Form CL-1A (2/13)

ACCIDENT INDEMNITY CLAIM FORM

UNITED TRANSPORTATION UNION INSURANCE ASSOCIATION

A Fraternal Benefit Society

24950 COUNTRY CLUB BLVD., STE. 340 NORTH OLMSTED, OHIO 44070-5333

TELEPHONE (216) 228-9400 FAX (216) 228-0411

The furnishing of this blank shall not be held to be a waiver of any conditions of your policy.

Policyholder Information: *(please print)*

Policy Number: ________________________ Local Number:_________________

Policyholder's First Name:_______________________ Initial: _____ Last Name: ____

Street Address:____

City: ________________________________ State:______________________ Zip Code:____________________________________

Patient Information: *(please print)*

First Name: ___________________________________ Initial: _____ Last Name:____

Relationship: Policyholder:_______ Spouse:_________ Dependent Child: ________ Patient's Birth Date: _____________

Please have the patient sign bottom of claim form. If patient is under 18 years old, please have parent or guardian sign.

Date of Accident: _______________________________

Name Injury and furnish details of when, where, and in what manner it occurred. Attach separate sheet if necessary

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____

Were you transported by ambulance? (yes or no) ________

If yes, was your ambulance transport by ground or air? ____________________

If yes, please submit supporting documentation of transport.

Did you receive emergency treatment from a Physician, at a Hospital, or was an X-ray taken? ________ (yes/no)

If yes, please submit supporting documentation of emergency treatment.

If Hospitalized: ____

Name of Hospital *City* *State*

Admitted:_____________________________________ Discharged: __________________________________

ICU dates of admission and discharge (If applicable): Admitted: __________________ Discharged: __________________

If Hospitalized and /or confined to an intensive care unit, please send a copy of hospital bill showing dates.

Were any of the following diagnosistic exams performed for this accident MRI, CT or EEG?

If yes, please list and submit supporting documentation: ____

____

If any Physical Therapy is required for this accident, please list dates of treatment and **submit supporting documentation:**

____

Please send all medical proofs necessary to support your claim. The claim cannot be processed until all necessary information is provided. Failure to complete this form in its entirety may result in a delay in processing this claim

I hereby authorize any licensed physician, medical practitioner, clinic, hospital or other medically related facility, insurance company, or other person, organization or institution, that has any records or knowledge of me, to give United Transportation Union Insurance Association or its representative, any such information. A photocopy of this authorization shall be as valid as the original.

Date: ____________________ **Insured's Signature:** ____

Mailing Address (Street, City, State, Zip): ____

Social Security No: ____________________ **Telephone No.:** ____________________ **Cell No:** ____________________

Required for Payment

ATTENDING PHYSICIAN'S STATEMENT

Any expense incurred in the furnishing of this report is to be borne by the claimant.

Patient's Name: ______________________________ Age: __________

Medical Diagnosis: ______________________________ ICD Code: __________

Date accident occurred: __________ Date patient first consulted you for this condition: __________

Did the patient receive emergency treatment from a Physician, at a Hospital, or was an X-ray taken? Yes _____ No________

Was patient hospitalized as an inpatient: Yes ________ No_________ If yes, please provide name of hospital

Hospital: ______________________________ City: __________ State:_______

Admitted Date: __________ Discharge Date: __________

Was patient admitted to ICU? Yes _________ No____________

If yes, please list dates: Admitted Date: __________ Discharge Date: __________

PLEASE ANSWER ONLY THE QUESTIONS BELOW THAT ARE APPLICABLE FOR THIS ACCIDENT

DISCLOCATION:	Location of Dislocation: __________ Is the Dislocation an Open Reduction or a Closed Reduction? __________
BURNS:	Is the burn considered a 2nd or 3rd degree? __________ Size of Burn in square centimeters: __________ Was Skin Graft performed? Yes ________ No________
EYE INJURY:	Describe Eye Injury: __________ __________ Was surgery used to repair the eye injury or remove foreign body from eye? __________ Please Explain:__________ __________
LACERATIONS:	Date of Laceration:__________ Describe Laceration(s):__________ __________ Length of Laceration(s) in centimeters: __________ Were Sutures used? Yes:________ No: __________
FRACTURES:	Number of Fractures:__________ Locations of Fractures: __________ __________ Were the fractures listed as open reduction or closed reduction: __________
COMA:	Did the patient suffer a coma as a result of this accident? Yes _______ No __________ Was the coma medically induced or sustained as part of your course of treatment? __________
PARALYSIS:	Did the patient suffer paralysis as a result of this accident? Yes _________ No____________ If yes, how long: __________ Is the paralysis Quadriplegia or Paraplegia?__________
SURGERY:	Was surgery performed for this accident? Yes _____No _____ Date surgery performed:________ If yes, describe surgical procedure performed: __________ __________
MAJOR DIAGNOSTIC EXAMS:	Were any of the following diagnosistic exams performed for this accident MRI, CT or EEG? If yes, please list: __________
PHYSICAL THERAPY	Does this patient require any Physical Therapy for this accident?(yes/no)__________ Date Physical Therapy Started:__________ Number of Treatments: __________
PROSTHESIS	Does the patient require a Prosthetic Device as a result of this accident? (yes/no) __________

Physician Name (PRINT) __________ **Signature:** __________ **Degree:** ________

Address: __________ **City:** __________ **State:** ________

Zip: __________ **Telephone No. (   )** __________ **SS# or TIN:** __________ **Date:** __________

FRAUD WARNING

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. (O.R.C. -Sec.3999.21)

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.