Form CL-1H REV 2/13

CANCER AND HOSPITAL 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's Name, Address and Local Number (please print)

IF THIS CLAIM IS FOR THE DIAGNOSIS AND/OR HOSPITALIZATION OF CANCER, PLEASE READ AND COMPLY WITH THE FOLLOWING.

1. PLEASE COMPLETE ALL PORTIONS OF THIS CLAIM FORM. THE FRONT PORTION BY YOU AND THE BACK PORTION BY YOUR PHYSICIAN.

2. PLEASE SUBMIT HOSPITAL BILLING STATEMENT INDICATING THE DATES OF INPATIENT ADMISSION AND DISCHARGE.

3. A PATHOLOGY REPORT FIRST DIAGNOSISING CANCER MUST ACCOMPANY YOUR INTIAL CLAIM. (THE HOSPITAL OR DOCTOR WILL FURNISH THIS REPORT TO YOU AT YOUR REQUEST.)

IF THIS CLAIM IS FOR HOSPITALIZATION OF ANYTHING OTHER THAN CANCER, PLEASE READ AND COMPLY WITH THE FOLLOWING.

1. PLEASE COMPLETE ALL PORTIONS OF THIS CLAIM FORM. THE FRONT PORTION BY YOU AND THE BACK PORTION BY YOUR PHYSICIAN.

2. PLEASE SUBMIT HOSPITAL BILLING STATEMENT INDICATING THE DATES OF INPATIENT ADMISSION AND DISCHARGE.

Policy Number: _____

Patient Information: (please print)

Patient's First Name:_____ Initial: _____ Last Name: _____

Relationship: Policyholder: _____ Spouse: _____ Dependent Child: _____ Patient's Birth Date: _____

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

Please list illness that you are claiming and date symptoms first appeared._____

_____

Were you hospitalized as an inpatient as a result of this diagnosis? (yes/no) _____

If yes, please give name, city, and state of hospital with dates of inpatient confinement:

Name of Hospital: _____

City: _____ State: _____

Admit date(s): _____ Discharge date(s):_____

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:

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:

When did symptoms first appear? _____

When did patient first consult you for this condition? _____

Has patient EVER been diagnosed or treated for any type of internal cancer or melanoma? (yes/no) _____

If yes, state when and describe: _____

_____

Please indicate and describe any surgical procedure performed. _____

_____

_____

Was patient hospitalized as an inpatient as a result of this diagnosis? (yes/no) _____

If yes, please give name, city and state of hospital with dates of inpatient confinement:

Name of Hospital: _____

City: _____ State: _____

Admit date(s): _____ Discharge date(s): _____

If patient has been diagnosed with cancer, was a bone marrow transplant performed? _____

Physician's 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.