



Please complete this Loss of Income claim form by typing or printing clearly in ink and returning to:

Coordinated Benefit Plans Incorporated
P.O. Box 20874
Tampa, FL 33622-0874
Toll Free Number: 800-753-1000

A. TO BE COMPLETED BY THE CERTIFICATE HOLDER

Name of Association _____ Policy Number _____

Name _____ I.D. Number _____ Date of Birth _____

Current Home Address _____
Number and Street _____ City _____ State _____ Zip Code _____

Effective Date of Coverage _____ Phone No. _____ E-mail Address _____

Is this claim related to illness or injury

If injury, please provide the date, time and details of accident. Include activity engaged in at time of injury _____

Description of injury _____

Have you ever been treated for a similar condition before? Yes No If yes, please provide the name, address and phone number of the treating physician _____

Is there other coverage in force that provides disability benefits? Yes No If yes, provide name and address of insurance company and/or administrator and policy ID# _____

AUTHORIZATION: I hereby authorize Fairmont Specialty, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and /or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

SIGNATURE OF CERTIFICATE HOLDER _____ DATE _____

B. TO BE COMPLETED BY THE EMPLOYER

Name of Employer _____ Claimant's Occupation _____

Description of job duties _____

Employer's Address _____
Number and Street _____ City _____ State _____ Zip Code _____

Claimant's current annual salary \$ _____ Claimant's date of hire _____ Last date worked _____

Expected return to work date _____ Are you aware of any work related illness or injuries for this claimant? Yes / No

If yes, please provide details _____

Print name of employer representative _____ phone # _____

Position of employer representative _____

Signature of employer representative _____ Date _____

C. TO BE COMPLETED BY THE ATTENDING PHYSICIAN

STATEMENT OF ATTENDING PHYSICIAN

Patient's Name: _____ Date of Birth: _____

1. Complete Diagnosis: _____

2. Is condition a result of illness injury If injury, how do you understand the accident occurred? _____

3. Has the patient had treatment for the same or related condition before? Yes No

If yes, when and by whom? _____

4. Was Patient Hospitalized? Yes No If yes, please give name, address of hospital and date of Confinement(s):

Name of facility	Address	Dates – From/To

5. First Date of Treatment _____ Last Date of Treatment _____ Next Date of Treatment _____

6. This disability would be categorized as:

Partial Disability – Patient is able to perform one or more, but not all of the major duties of his/her job.

Dates of Partial Disability From _____ through _____

Total Disability – Patient is unable to perform all of the major duties of his/her job.

Dates of Total Disability From _____ through _____

7. Expected Return to Work Date _____ Will patient resume full duties upon return to work? Yes / No

If no, please explain _____

Physicians Name and Address _____
Number and Street City State Zip Code

Physician's Phone Number _____ Fax Number _____ TIN or SS # _____

SIGNATURE OF PHYSICIAN _____ DATE _____

IMPORTANT NOTICE

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application of files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

Notice to Arizona Claimants: 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.

Notice to California Claimants: For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.

Notice to Colorado Claimants: It is unlawful to knowingly provide false, incomplete, or misleading 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or aware payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to Hawaii Claimants: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

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

Notice to Kentucky Claimants: 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.

Notice to Oklahoma Claimants: 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.

Notice to Pennsylvania Claimants: 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.

Notice to Texas Claimants: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.