Individual Long Term Care Claim Form
Claimant's Statement

You must complete this form in full.
Please print or type all information except where signature is required.
Please return the completed form to the insured or authorized representative or to CNA Insurance Companies, P.O.Box 64912 St. Paul, MN 55164-0912

Name of Insured	Date of Birth	Social Security Number	
Street Address	City	State	Zip
Phone Number ( )	Policy Number(s)		

Name of closest relative/Power of Attorney (if applicable, please enclose a copy of the legal documents)		Relationship	
Street Address	City	State	Zip
Phone Number: Home	( )		
Work	( )		

1. What type of benefits are you filing for?
   ❑ Nursing Home / Facility ❑ Home Health Care ❑ Other ________________

   Please provide the reason or condition for which you require care: ________________
   How long do you anticipate the need for care? ________________
2. Were you in the hospital within 30 days prior to receiving Facility or Home Health Care? ❑ Yes ❑ No
   If yes, please give the dates of hospitalization and the name of the hospital where you were a patient.
   Date Admitted ________________ Date Discharged________________
   Hospital Name | Hospital Phone Number ( )
   Address
3. Please provide the name and address of your attending / primary physician (if you have more than one, please list the physicians information on the reverse side of this form):
   Name | Phone Number ( )
   Address
4. Is Medicare or Medicaid providing benefits for any services for which you are filing this claim? ❑ Yes ❑ No
   Please list all other insurance coverage, including Medicare or Medicare HMO.
   Insurance Co. Name/Phone #: ________________
   Insurance Co. Name/Phone #: ________________

I have read and understand the penalties imposed by various states for misrepresentation of information.

Signature of Claimant or Authorized Representative ________________