When you need benefits under your Long-term Care / Facility Care / Home Health Care Coverage

INTAKE UNIT

We want to help you use the benefits available under the terms of your policy. Before you file a claim, you or your authorized representative can telephone our Intake Specialists for assistance. These representatives can provide information on policy benefits, claim filing, processing times and more! Please telephone 1-800-541-2254 and ask for the Intake Unit.

CLAIM FORM

Once your care begins, complete the attached "Long-Term Care and Claim Form."

Please keep the following items in mind as you complete the claim form.

1. Make certain to provide as much detail as possible to each of the following 10 questions. This includes providing current addresses and telephone numbers for questions 1, 2, 6, and 7. Providing incomplete information may lengthen claim processing time.

2. Question 7 allows you to describe a facility confinement under section "A" and/or care services under section "B." Make sure to provide complete responses regarding services you have received.

3. Feel free to attach additional pages if you need more room to respond to any question.

4. Before returning the claim form, collect and attach copies of:

   - ☐ All available bills for services rendered
   - ☐ Provider license, Medicare certification or other credentials
   - ☐ Provider Plan of Care (POC) or Service Plan
   - ☐ Minimum Data Sets (MDS) (for Facility claims only)
   - ☐ Daily Visit Notes (for Home Health Care & Hospice claims only)
   - ☐ Any available cognitive evaluations or testing
   - ☐ Proof of Legal Authority (e.g. Power of Attorney) of any person that represents you, if available

   NOTE: Additional information may be requested.

5. Return your completed claim form and all attachments to Washington National Insurance Company via fax number 1-317-817-2276 or PO Box 1902, Carmel, IN 46082-1902. The claim department will contact you within ten to fifteen business days of its receipt of your documents.

QUESTIONS

If you have any questions about your coverage or filing a claim, please call 1-800-541-2254.

(06/14) 153466

Authorization for Claims Processing Purposes
Pursuant to the HIPAA Privacy Rule 164.508(c)

I, the undersigned, authorize any licensed physician, medical practitioner, hospital, clinic, medical or medical related facility, the Veteran's Administration, insurance company, the Medical Information Bureau, Inc. (MIB), employer or Government agency to disclose personal information about me as described below.

This authorization was prepared by Washington National Insurance Company for purposes of obtaining personal information necessary to process a claim for benefits. The information subject to this authorization is any and all information, including health information, requested by Washington National Insurance Company for the purpose stated above as well as any information provided to them or their affiliated insurance companies on any previous applications. The information covered by this authorization does not include psychotherapy notes but does include any information about drug abuse, alcoholism, and mental illness. In addition, the information covered by this authorization does include any such information that has been restricted by my request.

Persons or entities employed by or authorized by Washington National Insurance Company to perform tasks related to the claims process are hereby authorized to use the personal information covered by this authorization. I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information will likely no longer be protected by the federal privacy regulations and may be subject to redisclosure. However, I further understand that all such persons or entities have signed agreements to protect said information.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Washington National Insurance Company, or, so long as Washington National Insurance Company has a legal right to contest the coverage or a claim under the coverage. Revocation requests must be sent in writing to:

Washington National Insurance Company
Privacy Office
PO Box 1902
Carmel, IN 46082-1902

I understand that Washington National Insurance Company cannot condition the payment of a claim on my signing this authorization. This authorization will expire upon the final action related to the claim for which this authorization is signed.

A copy of this authorization may be used in place of the original. If this authorization is for someone other than myself, that individual and my authority to act on his/her behalf are explained below.

(Please Print) Name of Individual Whose Information is Covered By This Authorization

(Please Print) Name of Representative with authority to act on behalf of the Individual Whose Information Is Covered By This Authorization

Signature of Individual and Date

Relationship of Representative to Individual

Signature of Representative and Date

LONG-TERM CARE CLAIM FORM

POLICY NUMBER:
_____

If you would like assistance in completing this claim form, please call 1-800-621-3724.

Please send completed claim form to:
Washington National Insurance Company
PO Box 1902, Carmel, IN 46082-1902

1. Claimant Name: _____ Date of Birth: _____ / ____ / ____

   Address *(if address is new, check box ☐):*_____

   City:_____ State: _____ Zip:_____

   Phone: (_____) _____ Sex: ☐ M ☐ F

2. Contact Person (if unable to reach) Name:_____

   Address:_____

   City:_____ State: _____ Zip:_____

   Phone: (_____) _____ Relationship: _____

3. Describe your limitations. Indicate the first day the limitations were present, if applicable, or provide an approximate time frame: _____

   _____

   _____

   _____

   _____

   _____

   _____

4. Cause or Condition which requires you to need Long-Term Care: ☐ Sickness ☐ Injury

   _____

   _____

   _____

   _____

   _____

   _____

   If limitations caused by an injury, when, where, and how did it happen? _____

   _____

5. Are you currently, or have you been, hospitalized within the last year? ☐ Yes ☐ No

   From:____ / ___ / ____ To:____ / ___ / _____ Hospital Name:_____

   Address:_____

6. List your medical history during the **last two years** below, starting with most recent treatment.
(Please attach additional pages if necessary.)

Name of Physician: _____

Phone: (_____) _____ Address: _____

City: _____ State: _____ Zip: _____

Condition(s) treated: _____ Date(s): _____

Name of Physician: _____

Phone: (_____) _____ Address: _____

City: _____ State: _____ Zip: _____

Condition(s) treated: _____ Date(s): _____

Name of Physician: _____

Phone: (_____) _____ Address: _____

City: _____ State: _____ Zip: _____

Condition(s) treated: _____ Date(s): _____

7. Please complete the information in either Box A or Box B for services already provided.
(Please attach additional pages if necessary.)

A. NURSING HOME OR ASSISTED LIVING FACILITY CONFINEMENT:

Name of Facility: _____ Tax ID: _____

Contact Person, if known: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Admitted: ____/ ____/ ____ Discharged: ____/ ___ /____ Payer Source: _____

B. HOME HEALTH CARE, ADULT DAY CARE OR OTHER CARE SERVICES:

Name of Care Provider: _____ Tax ID: _____

Contact Person, if known: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

Admitted: ____/ ____/ ____ Discharged: ____/ ___ /____ Payer Source: _____

8. Do you currently have coverage for medical care under Medicare?
(If yes, is coverage for Part A or Part B only, or for both?)

☐ Part A only ☐ Part B only ☐ Parts A&B ☐ No Medicare Coverage

Has a claim been submitted? ☐ Yes ☐ No

9. Do you have any other insurance that may provide coverage? **Check all that apply:**

☐ Coverage under a Medical Plan
Company _____ Policy Number: _____
Phone Number: (_____)_____ Has a claim been submitted? ☐ Yes ☐ No

☐ Medicare Supplemental Policy
Company _____ Policy Number: _____
Phone Number: (_____)_____ Has a claim been submitted? ☐ Yes ☐ No

☐ Other Third Party Coverage (Auto Insurance, Injury/Accident, Property Insurance, etc.)
Company _____ Policy Number: _____
Phone Number: (_____)_____ Has a claim been submitted? ☐ Yes ☐ No

☐ Workers' Compensation
Company _____ Policy Number: _____
Phone Number: (_____)_____ Has a claim been submitted? ☐ Yes ☐ No

☐ Other Long-Term Care Insurance
Company _____ Policy Number: _____
Phone Number: (_____)_____ Has a claim been submitted? ☐ Yes ☐ No

☐ No Insurance

☐ Unknown

10. Do you have a Power of Attorney, Conservator, or Guardian or other person who can legally represent you?*
If Yes, who?

Name:_____ Phone Number: (_____)_____

Address: _____ City: _____ State:_____ Zip:_____

***Please attach to this form a copy of the document giving this person legal authority.**

For your protection some states require us to inform you that any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed. If we determine that benefits have been paid under this coverage as a result of your fraudulent action(s), we have the right to recover those benefit amounts. We may recover those benefit amounts directly from you or by reducing any subsequent benefit payments under this coverage. We will determine the manner in which we seek recovery of benefit payments made under fraudulent conditions.

I declare that all of the above answers are complete and true to the best of my knowledge and belief. I understand that the company reserves the right to require further proof.

X _____ _____ / _____ / _____
Signature of Policyholder (or Legal Representative) Date signed (Month/Day/Year)

_____ _____
Policyholder (or Legal Representative) Name (Please Print) Signed at (City, County, State)

_____
If Legal Representative, give relationship to Policyholder

AK residents: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ residents: 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.

AR residents: 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.

CA residents: 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.

CO residents: 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.

DC residents: 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, the insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

DE residents: A 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.

FL residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

ID residents: 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.

IN residents: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

KY residents: 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.

LA and RI residents: 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.

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

ME / TN / VA and WA residents: 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.

MN residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH residents: Any person who, with the 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 N.H. Rev. Stat. Ann. 638:20.

NJ residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss of 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.

NY residents: 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.

OH residents: 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.

OK residents: 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.

OR residents: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

PA residents: 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.

PR residents: Any person who, knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony, and upon conviction shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravated circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if attenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TX residents: 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 prision.

WV residents: 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.

All other states residents: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

Washington National Insurance Company
Home office: PO Box 1902, Carmel, IN 46082-1902

ADDRESS CHANGE REQUEST

All address change requests must be submitted in writing. Use this form to request a permanent change of address. Please allow 15 days for the address change to be processed.

Policyholder's Name:_____

Claimant's Name:_____

Policy Number(s):

_____ _____

_____ _____

PLEASE CHANGE MY ADDRESS TO:

Address:_____

City:_____ State: _____ Zip code:_____

Contact Telephone Number: (_____) _____

_____ _____ / _____ / _____
Signature of Policyholder (or Legal Representative) Date signed (Month/Day/Year)

_____
Printed name of Legal Representative, if other than insured. Give relationship to Policyholder.
(Attach a copy of your legal authority, Power of Attorney, guardianship, etc. if not already on file.)

PLEASE NOTE:

This address change will affect all correspondence being sent to the policyholder by Bankers, such as: Premium Statement, Claim Checks, Explanation of Benefits (EOB).

This form **must be signed and dated by the policyholder or Legal Representative** in order to be considered valid. Without proper signature(s) or documentation, this document is null and void.

If you have further questions please feel free to contact our Customer Service Department at 1-800-541-2254 between the hours of 8:00 AM – 4:30 PM Central Time, Monday through Friday.

Please mail Address Change Request Form to:

Claims Department
PO Box 1902
Carmel, IN 46082-1902
Or
Fax to: 317-817-2276