Allstate
HEALTH SOLUTIONS

Claim Filing Kit: Sickness Hospitalization

This form may be used to file claims for the Sickness Indemnity Rider.

1. Complete section one. Please include the policy number of your Accident Medical Expense with the Sickness Indemnity Rider plan.

2. Complete section two. Sign and date the form.

3. Send this claim form and copies of itemized inpatient hospitalization bills to the following address, fax number, or email:

Mail: Allstate Health Solutions
P.O. Box 3252
Milwaukee, WI 53201-3252
Fax: 317-284-7281
Email: NationalGeneral.customerservice@keybenefit.com

If you have any questions about this form, please call (855) 212-5014.

Failure to complete the entire claim form
may result in a delay of claims review.

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Please print clearly

Section 1

Information on Primary Policyholder

Policy Number: _____

Policy Owner Full Name: _____

Street Address: _____

City: _____ State: _____ Zip:_____

Phone Number: _____ Date of Birth: _____

Check this box if address is new: ☐

Information on Claimant

Claimant Full Name: _____

Gender: Male ☐ Female ☐ Date of Birth: _____

Relationship to Policy Holder *(circle one)* : Self Spouse Child Other

Phone Number: _____ Email Address: _____

Reason for filing claim: _____

_____

_____

We may need to request additional information. Please provide the following:

Primary Care Physician

Name: _____

Address: _____

Phone: _____

Have you ever had this condition before? ☐ Yes ☐ No

If yes, when? _____ (MM/DD/YY)

List all providers, including pharmacies, who have treated you for the past 5 years (Include name, address & telephone number): _____

_____

_____

_____

Claimant name:
Claimant date of birth:
Provider/Facility (completed by Insurer/Requester at time of request): _____

Authorization for the Release and Disclosure of Confidential Medical Information

The records and information obtained pursuant to this Authorization will be disclosed to National Health Insurance Company, Integon National Insurance Company, and/or Integon Indemnity Corporation (collectively "Allstate Health Solutions"), any consumer reporting agency authorized by Allstate Health Solutions, its legal representative(s), its third party administrator(s) (including Key Benefit Administrators), or any medical records retrieval service Allstate Health Solutions may engage, including, but not limited to, American Retrieval Company, and its agents.

I, or my legal representative, do hereby authorize any and all of my medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records' custodians, or any other health care provider to release any and all records and information, including diagnosis, testing, treatment and prognosis of my physical or mental condition, within their possession, custody or control regarding me in accordance with this Authorization. Such records and information to be released may include, but not to be limited to the following: alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, Human Immunodeficiency Virus (HIV) testing and treatment, Acquired Immune Deficiency Syndrome (AIDS), Sexually Transmitted Disease (STD) testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's. I understand that the purpose of this disclosure is to evaluate the eligibility of benefits or my claims for payment with respect to my insurance coverage with Allstate Health Solutions.

This authorization will remain in effect for a maximum of one year from the date of my signature below.

I understand that I may revoke this authorization at any time by sending a written notification via U.S. Mail to Attention: Privacy Department, P.O. Box 2070, Milwaukee, WI 53201-2070 or fax to 317-284-7281. I understand that a revocation of this authorization is not effective if Allstate Health Solutions has relied on the protected health information or has a legal right to contest a claim under an insurance policy or to contest the coverage itself. This revocation will be effective for future uses and disclosures only and will not apply to information that has already been used or disclosed in reliance on this authorization. Once health information about me has been disclosed by Allstate Health Solutions to a third party, the health information may be subject to redisclosure by the recipient and no longer be protected by federal privacy laws. If I choose not to sign this authorization or if I later revoke it, I understand that Allstate Health Solutions may not be able to process my application for coverage; if coverage has been issued, Allstate Health Solutions may not be able to administer my claim for benefits and this may result in a denial of my claim for benefits or request for services. Your provider may require you to complete an additional authorization form. If asked to complete this authorization, your prompt response will help expedite the process.

Claims submitted on dependents 18 and older require an authorization signed by the dependent.

Signature of claimant/legal guardian	Relationship of legal guardian
Print name of claimant/legal guardian	Date signed (mm/dd/yyyy)

If signed by the legal representative, please describe the authority under which the representative is authorized to act and enclose any related documentation granting authority.

Signature of legal representative	Relationship
Print name of legal representative	Date signed (mm/dd/yyyy)

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Fraud Warning Notices:

For states not listed below: 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 falseinformation or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subject such person to criminal and civilpenalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas & West Virginia: Warning - 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.

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

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

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

Ohio: 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.

Oklahoma: Warning - Any 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.

Texas: 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.