ASSURANT Health

SICKNESS CLAIM FORM

Time Insurance Company
PO Box 1739
Fort Mill, SC 29716
1-866-387-3405 (Toll-free) / 1-866-387-3406 (fax)

To File a Claim:

Complete **Section 1** – Attach an itemized bill **or** have the Provider/Attending Physician complete **Section 2**.

Complete **Section 3** with the claimant's signature. Submit the claim form and itemized bill (if applicable) to the address above.

Include: (if applicable)
- ☐ Hospitalization - a copy of the hospital bill indicating your diagnosis and days hospitalized
- ☐ Surgery - a copy of the operative report
- ☐ Cancer – a copy of the pathology report
- ☐ Dependent over age 18, Full-time Student – copy of proof of full-time student status from the institution's Registrar
- ☐ Death – a certified copy of the death certificate for the deceased

SECTION 1: Claimant's Information | **Policyowner's Information**

Claimant's Information			Policyowner's Information		
Last	First	MI	Last	First	MI
☐ Male ☐ Female	☐ Single ☐ Married	Birth Date	Address		☐ Check if New Address
Relationship to Policyowner:	☐ Self ☐ Spouse ☐ Dependent ☐ Check if dependent is full-time student		City	State	Zip
Policy No.			Social Sec. No. (optional)	Phone No.	Birth Date

FILING CLAIM FOR: ☐ Sickness ☐ Pregnancy ☐ Heart/Stroke ☐ Cancer ☐ Disability ☐ Deceased - Date: ____/____/____

SECTION 2: Attending Physician Statement – Have a physician complete this section or submit an itemized bill (HCFA 1500 or UB92)

Name & Address of Facility where Services Rendered

Date patient first consulted you for this condition: ____/____/____ If Pregnant, date of delivery: ____/____/____ ☐ Actual ☐ Expected

Has any other physician ever treated the patient for this condition? ☐ Yes ☐ No

If yes, physician's name: ______________________ Phone: (   ) ______________

Anesthesia Administered? ☐ None ☐ Local ☐ Non General ☐ General

If patient was hospitalized: Admission date: ____/____/____ Discharge ____/____/____

Hospital Name: ______________________ City ______________ State ________

A. Date(s) of Svc.	B. Place of Service	C. Describe Procedures, Medical Services or Supplies Furnished for each Date — Procedure Code	Explain Unusual Services or Circumstances	D. Diagnosis Code	E. Charge

Patient Acct No. ______________ Tax ID: ______________ Total Charge ________

Physicians Name - printed ______________ Signature ______________ Date ________

SECTION 3: Claimant Authorization and Signature

I hereby request and authorize you to furnish to Time Insurance Company or its representatives any and all medical information concerning any illness or injury I may have suffered. (Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same authority as the original.

Signature of Claimant (If minor, parent must sign) ______________ Relationship to Claimant ______________ Date ________

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.