

STANDARD CLAIM FORM

RESERVE NATIONAL INSURANCE COMPANY

601 East Britton Road
Oklahoma City, Oklahoma 73114

ATTENDING PHYSICIAN'S REPORT

1. PATIENT'S NAME	2. ADDRESS	3. AGE
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4. DIAGNOSIS (EXPLAIN COMPLICATIONS)

5. ADDITIONAL DIAGNOSES (CHRONIC DISEASE OR DEFECT FOUND DURING PRESENT TREATMENT)

6. DATE OF ONSET	7. DATE FIRST CONSULTED	8. DUE TO PREGNANCY <input type="checkbox"/> YES <input type="checkbox"/> NO	9. COMPENSATION CASE <input type="checkbox"/> YES <input type="checkbox"/> NO	10. WHEN, IN YOUR OPINION, DID PATIENT FIRST BECOME AWARE OF SOME SYMPTOM OF THIS CONDITION?
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11. SURGICAL OR OBSTETRICAL PROCEDURES (DESCRIBE)

12. IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL	13. DATE ADMITTED	14. DATE DISCHARGED
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15. NAME AND ADDRESS OF OTHER PHYSICIANS WHO HAVE TREATED PATIENT FOR THIS ILLNESS OR INJURY

COMPLETE IF PATIENT HAS INDICATED LOSS OF TIME BENEFITS

16. TOTAL DISABILITY: FROM _____ TO _____
17. PARTIAL DISABILITY: FROM _____ TO _____

AUTHORIZATION TO PAY PHYSICIAN

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ATTENDING PHYSICIAN FOR THIS ILLNESS OR INJURY, OF THE PHYSICIAN'S OR SURGEON'S BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED MY INDEBTEDNESS TO SAID PHYSICIAN. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE PHYSICIAN FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

DATE _____ SIGNED: _____
INSURED

IS

18. THE HOSPITAL IS NOT AUTHORIZED TO FURNISH, WITH THE INSURED'S CONSENT, ANY INFORMATION REGARDING THIS CLAIM REQUESTED BY

THE _____ INSURANCE COMPANY.

SIGNED _____ PHYSICIAN _____ DEGREE _____ DATE _____

SOCIAL SECURITY NO. _____ ADDRESS _____ STREET _____ CITY AND STATE _____ ZIP CODE _____
OR EMPLOYER I.D. NO. _____

NOTE TO PHYSICIAN. PLEASE SUBMIT YOUR ITEMIZED STATEMENT FOR THIS CLAIM. OKLAHOMA PHYSICIANS MAY USE OSMA FORM 102.

INSURED'S STATEMENT

TO BE COMPLETED PERSONALLY BY THE INSURED

YOUR DOCTOR OR HOSPITAL IS NOT RESPONSIBLE FOR COMPLETION

POLICY NO. _____ CLAIM NO. _____

NAME _____ AGE _____ ADDRESS _____

1. IF ACCIDENT: GIVE DATE _____ DESCRIBE HOW AND WHERE IT HAPPENED _____

2. IF SICKNESS: GIVE NATURE OF COMPLAINTS _____

3. DATE YOU FIRST NOTICED SYMPTOMS OR REALIZED YOU WERE GETTING SICK _____ 4. DATE FIRST SAW A DOCTOR _____

5. HAVE YOU HAD SYMPTOMS OR TREATMENT FOR THIS SICKNESS BEFORE _____ 6. WHEN? _____

7. MEDICAL TREATMENT RECEIVED DURING LAST TWO YEARS _____

(SICKNESS) _____ (DOCTOR) _____ (YEAR) _____

8. ARE YOU MAKING CLAIM FOR LOSS OF TIME? YES NO

IF 'YES'; DATE FIRST STOPPED WORK: _____ FIRST DATE RETURNED TO WORK: _____

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO RESERVE NATIONAL INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASES WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE _____ SIGNED: _____
INSURED

Notice to Arkansas 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.

Notice to Colorado 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. 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.

Notice to Kentucky Residents

WARNING: 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.

Notice to New Mexico 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 civil fines and criminal penalties.

Notice to Oklahoma 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.

Notice to Texas Residents

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.