KEMPER Health

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY

P.O. Box 9988
Austin, TX 78766-9988
Telephone: 844-613-6245 Fax: 844-473-8084
Email: service@kemperbenefits.com
Website: kemperbenefits.com

ACCIDENT CLAIM FORM

Instructions to File a Claim:

- Please provide all bills associated with your claim, including treatment dates, total charges, diagnoses and procedure codes and/or itemized bills: HCFA 1500 or UB-92.
- If your accident is due to a motor vehicle collision, we will require a copy of the police report for all motor vehicle accident claims and any other incidents investigated by any law enforcement agency.
- Please provide Physician's documentation of your accidental injury.
- Please provide documentation of your first date of treatment following your accident.
- If the accident resulted in death, please include a certified copy of the death certificate for the deceased.
- To verify the contents of this form, the Insured and Claimant (if an adult) must sign and date the completed claim form.
- If an insured person is also covered by Medicaid or a state variation of Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means that instead of paying the benefits to the insured, we must pay the benefits to Medicaid or the medial provider to reduce the charges billed to Medicaid.

Insured/Claimant Statement

Insured's Name (Last, First, Middle)	Policy/Certificate #	Social Security No.	Date of Birth	Sex

Address (Street, City, State, Zip)	Phone Number (With Area Code)

Claimant's Name (Person who is injured)	Date of Birth	Relationship to Insured

Date of Accident:	Date of Initial Treatment:	If auto accident, please check your response:
		Driver ◯ Passenger ◯ Unknown ◯

Describe how and where it happened:

Is your accident related to your occupation? Please check your response: Yes ◯ No ◯

Is your accident covered by Worker's Compensation? Please check your response: Yes ◯ No ◯ Pending ◯

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN 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 DISEASE WHICH MAY INCLUDE BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINIAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HAVE REVIEWED THE IMPORTANT CLAIMS INFORMATION ON THE BACK OF THIS FORM.

DATE_____ INSURED'S SIGNATURE: _____

DATE_____ CLAIMANT'S SIGNATURE: _____