UltraComp Critical IllnessPLUS®
UltraComp Cancer CarePLUS®

Claim Form

Please check the box to indicate the type of claim(s) you are submitting:

☐ **Critical Illness Claims** ☐ **Cancer Care Claims**	☐ **Hospital Indemnity Claims**	☐ **Death Benefit Claims**
Complete Sections A, B, D	Complete Sections A, C, D	Please Call 1-800-963-4554

To be completed by the insured or authorized person: (PLEASE PRINT)

SECTION A

Form Completed By:

Address:
Street City State ZIP

Telephone Number: ( )_____

Insured's Name: Date of Birth: / / Social Security Number: __ __ __ – __ __ – __ __ __ __

Address:
Street City State ZIP

Telephone Number: ( )_____ Policy Number:_____

SECTION B

Diagnosed Condition:

Date of Diagnosis: / /

Has insured been diagnosed with this condition before? . . . . . ☐ Yes ☐ No
If yes, please list the date first diagnosed: / /

List the names, addresses and telephone numbers of the physicians treating you for this condition. Attach a separate sheet of paper if additional space is needed.

Physician Name:

Address:
Street City State ZIP

Telephone Number: ( )_____

Physician Name:

Address:
Street City State ZIP

Telephone Number: ( )_____

SECTION C

Hospitalization: If Insured has been hospitalized, complete the following:

Date of Confinement	Hospital	Address/Telephone Number	Diagnosis

SECTION D

Please read and sign the following:

AUTHORIZATION TO RELEASE RECORDS: I authorize any hospital, physician or other person who has attended me or examined me to furnish American Republic Insurance Company or its representatives all information pertaining to the history any progress of my case.

I agree that a photocopy or fax copy of this, my original authorization, shall be considered equally authentic.

Signed: _____ Date: _____/_____/_____

Relationship of authorized person: _____

FRAUD WARNING STATEMENT

Residents of California: 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.

Residents of Colorado: 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.

Residents of 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.

Residents of New Hampshire: Any person who, with a 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 RSA 638:20.

Residents of Pennsylvania: 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.

Residents of Tennessee: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

Residents of All Other States: For your protection, state law requires the following statement to appear on this form: WARNING: Any person who knowingly files a claim containing false, incomplete, or misleading information with intent to injure, defraud or deceive is guilty of a crime and may be subject to civil and criminal penalties. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

The furnishing of forms does not constitute an admission of liability on the part of the Company.

PLEASE RETURN COMPLETED FORM TO:

American Republic Insurance Company
Attention: Policy Claims
601 6th Avenue P.O. Box 10
Des Moines, Iowa 50301-0010