CLAIM REPORT FOR AMERICAN REPUBLIC INSURANCE COMPANY NURSING HOME INDEMNITY POLICY

Instructions: Be certain all questions on this side of the form are answered. The reverse side of this form is to be completed by your physician before it is returned to us.

1. Insured's statement

Name of Policyholder ______________________________

Policy Number or I.D. Number ______________________________

Name of Patient ______________________________ Date of Birth ______________

Address ______________________________

City ______________ State ______________ Zip Code ______________

Name of condition being treated? ______________________________

If due to sickness, when did first symptoms appear? ______________________________

If due to injury, give date of accident ______________________________

Where and how did accident occur? ______________________________

Do you have any other insurance or plan with any other company, plan, association or government association that provides benefits for nursing home care? . . . . ☐ Yes ☐ No

If yes, give the following details:

Name of Company or Plan	Policy Numbers	Address of Company or Plan
1. ______________	1. ______________	1. ______________
2. ______________	2. ______________	2. ______________
3. ______________	3. ______________	3. ______________

2. Please give name and address of your physician or any other doctors treating or who have treated this condition

1. Physician's Name ______________________________
   Address ______________________________
   City ______________ State ______________ Zip Code ______________
2. Physician's Name ______________________________
   Address ______________________________
   City ______________ State ______________ Zip Code ______________
3. Physician's Name ______________________________
   Address ______________________________
   City ______________ State ______________ Zip Code ______________

3. Please give name and address of health care facility

Name of Facility ______________________________

Address ______________________________

City ______________ State ______________ Zip Code ______________

Date of Confinement ______________________________

4. Authorization to release information

IMPORTANT! THE FOLLOWING AUTHORIZATION MUST BE COMPLETED BY BOTH THE PATIENT AND THE DOCTOR.

I authorize any physician, hospital, medical practitioner, clinic, insurance company, insurer or other organization or institution or person having any records, data or information concerning me or any member of my family to furnish such records, data or information as may be requested by such company to American Republic Insurance Company or its duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.

______________ Signature of Policyholder ______________ Signature of Attending Physician ______________ Signature of Patient

______________ Address of Policyholder ______________ Address of Attending Physician

City State Zip Code ______________ City State Zip Code

______________ Date

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

5. Physician's statement	Patient's name ___ Diagnosis ___ If due to sickness, when did first symptoms appear? ___ If due to injury, give the date of accident ___ Has the patient ever suffered previously from the same or similar condition? ☐Yes ☐No Date ___ List any secondary condition(s) and/or complication(s) ___ ___ Was the patient referred to you? ☐ Yes ☐ No If yes, give name and address of referring physician ___ ___ If the patient was hospitalized, indicate name and address of the hospital and dates of confinement ___ What is your prognosis for this patient? ___
6. Health care facility information and certification of medical necessity	Name and address of health care facility ___ ___ How is the facility licensed? ___ What type of nursing care is the insured receiving? ☐ Skilled ☐ Intermediate ☐ Custodial If the insured is in a skilled facility, do you certify the insured requires skilled nursing care? ☐ Yes ☐No If the insured is in a custodial or intermediate facility, do you certify they require confinement for medically necessary nursing care other than skilled nursing care because of an injury or sickness? . . . . ☐ Yes ☐ No
7. Home health aide information	If the insured is receiving services from a home health aide, do you certify they require these services in lieu of nursing home confinement to meet daily living needs? ___ Name and address of home health aide ___

Attending Physician's Signature ___

Social Security Number ___

Federal Tax Number ___

American Republic Insurance Company

National Headquarters, Des Moines, Iowa 50334