NATIONAL INCOME LIFE INSURANCE COMPANY
C/O NILICO Service Center

PO BOX 2500 • Waco, TX 76702
Phone (800) 516-4466 • Fax (254) 741-5705
Web www.nilife.com • Email CL@nilife.com

INSTRUCTIONS FOR SUBMITTING AN ACCIDENT, HEALTH OR DISABILITY WAIVER OF PREMIUM CLAIM

- ☐ **Accident Claims** - Complete Part A and Part E for all Claims, and Part B if policy is less than 2 years old.
- Include a copy of all itemized Hospital/Doctor bills and Proof of Treatment which include procedure and diagnosis codes.
- ☐ **Cancer Claims** - Complete Part A for all Claims, and complete Part B if policy is less than 2 years old.
- A Pathology report must be included in the initial claim for the diagnosis of Cancer.
- ☐ **Disability Waiver of Premium Claims** - Complete Part A for all Claims, and Complete Part B if policy is less than 2 years old.
- Have your Employer Complete Part C - 'Employers Statement'.
- Have the doctor complete Part D - 'Attending Physician's Statement'.
- ☐ Submit the form yourself, Do not leave it for the doctor to submit.

Part A - To be Completed by the Insured for all Claims

Policy Numbers ______ ______ ______

Policyowner's Name	Policyowner's Mailing Address
Policyowner's Employer	
Policyowner's Union and Local # *(if Union member)*	Policyowner's Occupation
Policyowner's Email Address	Policyowner's Phone #
Patient's Name	Patient's Date of Birth / Patient's Gender ☐ Male ☐ Female
Patient's Relationship to Policyowner ☐ Self ☐ Spouse ☐ Child ☐ Other ______	Does patient have any other insurance coverage which provided benefits for this claim? ☐ No ☐ Yes If yes, Name: ______
1. This Claim is in Connection with: (please check) ☐ Accident ☐ Cancer ☐ Disability Waiver of Premium	Was patient confined to hospital due to Accident/Illness claim? ☐ No ☐ Yes
2 . Date of Accident/Illness / 3 . Date First Treated	4 . Nature of Injury/Illness sustained & how it happened

5. Name & Address of Provider treating this condition

Release of Medical Information Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the National Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with National Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

National Income Life Insurance Company and I agree that this Claimant's Statement may be electronically signed. By typing my name below, I hereby agree that my electronic signature shall have the same effect as if it were handwritten. Further, I hereby attest that the information given herein is true and accurate to the best of my knowledge.

Patient's Signature ______________________ Date ______________

Part B - Health Information **ONLY COMPLETE IF POLICY IS LESS THAN 2 YEARS OLD**

List all sickness or injuries and physicians for which treatment was required in the past 5 years

Physician & Address	Condition	Date Symptoms Appeared	Date of Initial Treatment	Date Diagnosed

Part C - To be Completed by the Employer **DISABILITY WAIVER OF PREMIUM ONLY**

Employee's Name	Occupation
When did sickness or accident occur?	When did he/she cease work?

If injured, how did it happen?

When did employee resume any part of employee's work, supervisory or other?

Company Name	Phone Number

Street Address	City	State	Zip

Signature of Employer ______________________ Date ______________

Title ______________________

Part D - To be Completed by the Attending Physician

Patient's Name	Patient's Address
Patient's Date of Birth	
Diagnosis and current conditions: (If diagnosis code other than international classification of diseases, give name)	Does condition arise out of patient's employment? ☐ Yes ☐ No
	If Condition due to pregnancy, date pregnancy commenced

REPORT OF SERVICES (or attach itemized bill)

Date of Services	Place of Services	Description of Surgical or Medical Services	Procedural Code (Give name if not current terminology)	Charges
			TOTAL CHARGES	

IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT

Hospital	Address	Dates

Result of an Accident? ☐ Yes ☐ No	Date of Accident?
Date patient first consulted you for this condition	Patient still under your care for this condition? ☐ Yes ☐ No
Patient ever had similar condition? ☐ Yes ☐ No If yes, when:	Was patient referred to you? ☐ Yes ☐ No If yes, name and address of referring physician
Patient was continuously TOTALLY DISABLED (unable to work) From To	Patient was PARTIALLY DISABLED From To
If still disabled, date patient should be able to return to work	Does patient have any other health coverage? ☐ No ☐ Yes If yes, Name:

Please give name and address of any physicians or other practitioners you referred the patient to see

Name	Address	Phone

Physician's Name (Please print) ______________________________

Physician's Address ______________________ Phone ______________

Signature of Physician ______________________ Date ______________

Part E - AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Insured's Name	Date Of Birth	Social Security Number	Policy Number
Insured's Address			

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, Medical Information Bureau (MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the National Income Life Insurance Company (NILICO) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco; but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that NILICO may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with NILICO.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to NILICO, Attention: Claims Department, at the above address. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that NILICO has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, NILICO may not be able to process my claim or make any benefit payments. I have received a copy of this authorization.

Name and address of person(s) or category of person to whom this information will be sent	Name of person signing form:
National Income Life Insurance Company C/O NILICO Service Center PO Box 2500, Waco, TX 76702	

Authority to sign on behalf of Insured.

____ Parent ____ Legal Guardian ____ Child ____ Spouse ____ Next of Kin

____ Executor of Estate ____ Other (please specify relationship to Insured) - ____________________

All items on this form have been completed and my questions about this form have been answered. National Income Life Insurance Company and I agree that this Claimant's Statement may be electronically signed. By typing my name below, I hereby agree that my electronic signature shall have the same effect as if it were handwritten. Further, I hereby attest that the information given herein is true and accurate to the best of my knowledge.

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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

______________________________ ______________________

Signature of Patient/Beneficiary/Guardian or Personal Representative Date

Please make a copy of this authorization and retain for your record.