National States Insurance Company in Liquidation

c/o Missouri Life and Health Insurance Guaranty Association
2210 Missouri Boulevard · Jefferson City, MO 65109 · Phone (573) 634-8455 · Fax (573) 634-8488

LTD CLAIM FORM

		Residents of Arizona, Colorado Florida, Idaho, Kentucky, Louisiana, Minnesota, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas and West Virginia, please read the applicable Fraud Warning on the back of this form.
HOW TO FILE A DISABILITY OR LONG-TERM CARE INDEMNITY CLAIM	1. List all policy numbers on which claims are being filed in box above. 2. Answer all questions on your INSURED'S portion of the form. 3. Sign and date the Patient Authorization. 4. Have your doctor complete and sign the physician portion of the form. 5. Mail to Missouri Life and Health Insurance Guaranty Association.	

TO BE COMPLETED BY INSURED FOR DISABILITY OR LONG-TERM CARE INDEMNITY CLAIMS ONLY

1. Describe sickness or injury _____
2. Date accident occurred or illness began _____
3. Was hospitalization required? _____ If "yes," Date admitted _____ Date discharged _____
   Name and address of hospital _____
4. Name and address of doctors who attended you (attach additional sheet if necessary) _____
   _____
5. Date you first consulted a doctor for the condition _____
6. Date you were first disabled _____ Date your disability ended _____
7. Did you need assistance to perform normal Activities of Daily Living? [ ] Yes [ ] No
8. Please indicate which activities in which you needed assistance _____
   _____

PATIENT AUTHORIZATION (MUST BE COMPLETED)

National States Insurance Company in Liquidation (referred to as National States), its reinsurers, insurance support organizations, and their authorized representatives, may obtain medical and other information in order to evaluate my (our) claim for health insurance benefits.

Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc., my employer and consumer reporting agency or insurance company who possesses information of care, treatment or advice of me or my children may furnish such information to National States or its representative upon presenting this authorization or a photocopy.

This authorization includes information about drugs, alcoholism or mental illness.

This authorization will be valid from the date signed for a period not to exceed the terms of the policy under which claim is being made.

I have read this authorization and know that I, or any person I authorize to act on my behalf, may request a copy of it. I know that I may revoke this authorization at any time by notifying National States in writing of my wish to do so.

Date _____ Policyholder's Signature _____

(Wisconsin residents, please see authorization on the back side) Policyholder's Name _____

TO BE COMPLETED BY PHYSICIAN FOR LONG-TERM CARE INDEMNITY CLAIMS ONLY

1. Patient's Name _____ Age _____
2. Nature of sickness or injury _____
3. Date of onset _____ Date you were first consulted for this condition _____
4. Is patient unable to perform at least 2 Activities of Daily Living? [ ] Yes [ ] No Please circle all ADL's they are unable to perform
   Bathing Continence Dressing Eating Toileting Transferring
5. Date first disabled _____ Date disability ended _____
6. Is the patient severely cognitively impaired? [ ] Yes [ ] No
7. Prognosis _____
8. Estimated length of disability _____

Date _____ ***PHYSICIAN'S SIGNATURE*** _____

Address _____ Telephone # ( ) _____

Arizona Notice: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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. 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.

Florida Residents Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

Idaho Residents Notice: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

Kentucky Residents Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana and West Virginia Notice: 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 criminal penalties.

Minnesota Notice: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Mexico Notice: 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 confinement in prison.

North Carolina Notice: Any person who, with intent to defraud or deceive an insurer or insurance claimant, submits false or misleading information concerning a fact or matter material to a claim, is guilty of Class H felony.

Ohio Residents Notice: Any person who, with intent to defraud or knowing that he is facilitating a fraud against any insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents Notice: 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.

Pennsylvania Residents Notice: 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.

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

Texas Residents Notice: 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.

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and other non-medical information of me or my minor children to give to National States Insurance Company in Liquidation or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by National States Insurance Company in Liquidation to determine eligibility for benefits under an existing policy. Any information obtained will not be released by National States Insurance Company in Liquidation to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I or my authorized representative may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for the term of the policy under which claim has been made, or the pendency of the claim, whichever is longer.

Signed this _____ day of _____, _____

POLICYHOLDER'S SIGNATURE _____

Policyholder's Name _____

Policyholder's Email Address _____