HOSPITAL ADVANTAGE

Hospital Confinement & Additional Indemnity Benefits Insurance Plan

2.0

CLAIM FORM

SENTINEL SECURITY LIFE INSURANCE COMPANY
PO BOX 27248 SALT LAKE CITY, UTAH 84127-0248
STATE OF DOMICILE: UTAH

Sentinel® Security Life

Lighting the way to financial security

HOSPITAL ADVANTAGE 2.0

CLAIM FORM FOR SENTINEL PLAN® HOSPITAL ADVANTAGE®

PO Box 27248 Salt Lake City, UT 84127-0248 • Toll Free 800-247-1423 • Fax 888-433-4795

IMPORTANT: WHAT TO KNOW ABOUT FILING YOUR HOSPITAL INDEMNITY CLAIM

YOU CAN AVOID UNNECESSARY PROCESSING DELAYS BY MAKING SURE YOU PROVIDE ALL OF THE FOLLOWING:

• Please be sure to include your policy number on your claim form. To obtain your policy number or for additional information please call Policy Services at 800-247-1423.

• You may fax your claim to us at 888-433-4795. We will respond by mail within 15 business days of receipt of your claim.

• You may mail your claim to:
Sentinel Security Life Insurance Company
PO Box 27248
Salt Lake City, UT 84127-0248

• If you are filing a claim within the first 24 months of the policy being issued, additional information may be requested.

• Each claim submitted should include a fully completed Patient's statement.

• Please include a copy of all itemized hospital and physician bills that explain all procedures performed for this claim to be processed.
- Your medical provider may know them as UB04 (hospital); HCFA 1500 (physician) or physician super bill.
- This could include an Explanation of Medicare Benefits (EOMB), a Statement of Claim and/or a completed Physician's Statement.

NOTE: *Your Policy has a 6-Month Pre-Existing Condition Limitation and a 2-Year Policy Contestability Period.*

Sentinel Security Life

RETURN TO COMPANY

SENTINEL SECURITY LIFE INSURANCE COMPANY
PO Box 27248 Salt Lake City, UT 84127-0248 • Toll Free 800-247-1423 • Fax 888-433-4795

PATIENT'S STATEMENT

Policy Number _____

PATIENT'S CLAIM FORM

1. Insured's Name	2. Phone No. *(please include area code)*	3. E-mail Address

4. Address *(Street, City, State, Zip Code)* - **If Address is New, Please Check Box** ☐

PLEASE NOTE: It is important that all questions be answered in full and that this form be returned to Sentinel Security Life Insurance Company. If claim is for hospital or doctor expenses please attach itemized bills.

5. Patient's Name *(if other than the insured)*	6. Birth Date *(mm/dd/yyyy)*

7. Date patient became ill, accident occurred, or date of preventative care *(mm/dd/yyyy)*	7A. If accident, how did it happen? Please explain.

8. Date patient first saw any doctor for this condition if non-preventative care? *(mm/dd/yyyy)*	8A. Were you ever sick with this condition before? ☐ Yes ☐ No	8B. If YES, when *(mm/dd/yyyy)*

9. Doctor's Name and Address *(Street, City, State, ZIP)*

10. Did you or will you file a workers compensation claim? ☐ Yes ☐ No	10A. If YES, Employer's Name and Address *(Street, City, State, ZIP)*

11. If hospitalized, Name and Address of facility *(Street, City, State, ZIP)*

12. If care provided by nursing home, Name and Address *(Street, City, State, ZIP)*

13. Family Doctor Name and Address *(Street, City, State, ZIP)*

14. Other doctors seen during the last 2 years:

I understand that this information will be used by Sentinel Security Life Insurance Company for the purpose of evaluating my claim for insurance benefits. I declare that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative am entitled to receive a copy of this authorization upon request. **BE SURE TO SIGN BELOW.**

Name of Patient

Signature of Patient's authorized representative, or next of kin

Date Signed *(mm/dd/yyyy)*

IF PATIENT IS DECEASED, personal representative or next of kin must sign. **The furnishing of this form is not admission of any liability on the part of Sentinel Security Life Insurance Company.**

SSLHIPCLAIM REV 04/15

Sentinel Security Life

PHYSICIAN'S STATEMENT

PATIENT'S INFORMATION

1. Patient's Name *(First Name, Middle Int., Last Name)*	2. Alternate Name	3. Patient's Birth Date *(mm/dd/yyyy)*
4. Patient's Policy Number	5. If Preventative Care, Check Here ☐	6. Date of Illness *(injury, accident, first symptom or preventative care) (mm/dd/yyyy)*
7. Date first consulted for this condition *(mm/dd/yyyy)*	8. Has Patient had same or similar symptoms prior? ☐ Yes ☐ No	9. If Patient was seen for an emergency, Check Here ☐
10. Is this injury/sickness work related? ☐ Yes ☐ No	11. Name of referring physician or other source	12. For services related to hospitalization, provide hospitalization dates *(mm/dd/yyyy)* Admitted: ___/___/_____ Discharged: ___/___/_____
13. Name and Address of facility where services rendered *(if other than home or office)*		14. Was laboratory work performed outside your office? ☐ Yes ☐ No

15. Diagnosis or nature of illness or injury. Relate diagnosis to procedure in Column D by reference numbers 1, 2, 3, Etc. or DX Code (ICDA9)

1. 3.

2. 4.

16. A. Date of Service	B.* Place of Service	C. Fully describe procedures, medical services or supplies furnished for each date given Procedure Code (CPT) *(Identify)* *(Explain unusual services or circumstances)*	D. Procedure Code (CPT)	E. Diagnosis Code	F. Charges		G. Days or Units	H Type of Service**

17. Signature of Physician or Supplier	18. Total Charge	19. Amount Paid	20. Balance Due
Signed Date	21. National Provider I.D.	22. Physician's or Supplier's Name, Adress, ZIP, & Phone No.	
23. Your Patient's Account No.	24. Your Employer I.D. No.	I.D. Number.	

***PLACE OF SERVICE CODES**

- 11 - (O) Doctor's Office
- 12 - (H) Insured's Home
- 21 - (IH) Inpatient Hospital
- 22 - (OH) Outpatient Hospital
- 31 - (SNF) Skilled Nursing Facility
- 32 - (NH) Nursing Home
- 41 - Ambulance
- 51 - Night Care Facility (PSY)
- 53 - Day Care Facility (PSY)
- 99 - (OL) Other Locations
- A - Independent Laboratory
- B - Other Medical/Surgical Facility
- C - (RTC) Residential Treatment Center
- D - (STF) Specialized Treatment Facility

****TYPE OF SERVICE CODES**

- 1 - Medical Care
- 2 - Surgery
- 3 - Consultation
- 4 - Diagnostic X-Ray
- 5 - Diagnostic Laboratory
- 6 - Radiation therapy
- 7 - Anesthesia
- 8 - Assistance at Surgery
- 9 - Other Medical Service
- 0 - Blood or Packed Red Cells
- A - Used DME
- M - Alternate Payment for Maintenance Dialysis
- Y - Second Opinion on Elective Surgery
- Z - Third Opinion on Elective Surgery

List full name, address and phone # of your Primary Care Physicians:

Name	Phone		Date First Seen
Address	City	State	ZIP
Name	Phone		Date First Seen
Address	City	State	ZIP
Name	Phone		Date First Seen
Address	City	State	ZIP

List full name and address of any other medical providers who have treated you and their specialty:

Name	Phone	Specialty	Date First Seen
Address	City	State	ZIP
Name	Phone	Specialty	Date First Seen
Address	City	State	ZIP
Name	Phone	Specialty	Date First Seen
Address	City	State	ZIP
Name	Phone	Specialty	Date First Seen
Address	City	State	ZIP
Name	Phone	Specialty	Date First Seen
Address	City	State	ZIP

We ask that you make photocopies of any correspondence sent to our office to keep for your records.

Sentinel Security Life

FRAUD LANGUAGE

DEAR INSURED: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. ***Thank you.***

Alabama	**Arkansas**	**California**	**Connecticut**	**Georgia**	**Iowa**	**Illinois**
Kansas	**Louisiana**	**Massachusetts**	**Michigan**	**Missouri**	**Mississippi**	**Montana**
North Carolina	**North Dakota**	**Nebraska**	**Nevada**	**Puerto Rico**	**Rhode Island**	**South Carolina**
South Dakota	**Texas**	**Utah**	**Vermont**	**Wisconsin**	**West Virginia**	**Wyoming**

GENERIC FRAUD WARNING *(to be used for above states only)*
Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

ALASKA, DELAWARE, IDAHO, INDIANA, OKLAHOMA
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.

COLORADO, WASHINGTON D.C., HAWAII, MAINE, TENNESSEE, VIRGINIA
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance coverage.

ARIZONA, MINNESOTA, NEW JERSEY, NEW MEXICO
Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

KENTUCKY, OHIO, OREGON
Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

FLORIDA
Any person who, knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section 817.234 F.S.

MARYLAND
Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

PENNSYLVANIA
Any person who knowingly and with intent to defraud any insurance company or other person files 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.

RHODE ISLAND
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 confinement in prison.

WASHINGTON STATE
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.

NOTES

Sentinel Security Life Insurance Company

Since 1948, families have counted on Sentinel Security Life Insurance Company during their time of need. The Company was originally established to provide families a way of funding funeral expenses and burial costs. Through our final expense life insurance product, we have been honored to provide peace of mind to families for well over half a century.

Today, Sentinel offers a strong senior market portfolio including Life, Medicare Supplement and Annuity products. We continue to develop new products while improving existing products and services to better protect our customers.

Sentinel has a long history of financial strength and stability that has afforded us the opportunity to invest wisely in the growth of our company. Our strength lies not only in the quality of our insurance products, but also the level of service we provide to our policyholders, agents, and shareholders. We invite you to learn more about our company by visiting www.sslco.com or by calling 800-247-1423.

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