NATIONWIDE LIFE INSURANCE COMPANY
NATIONAL CASUALTY COMPANY
INDIANA VOLUNTEER GROUP INSURANCE

Claim Form | Group Insurance

NOTE – PLEASE READ THIS BEFORE SUBMITTING YOUR CLAIM

Indiana law requires that a volunteer firefighter or an emergency medical technician (EMT) working in a volunteer capacity for a volunteer FIRE company be covered by the medical treatment provisions of the INDIANA WORKERS' COMPENSATION and WORKERS' OCCUPATIONAL DISEASES ACTS. Consequently, medical expense benefits are not payable to these fire company volunteer firefighters and EMT's to the extent that the benefit would be collectible if they were covered by the medical treatment provisions of these two Acts. SUBJECT TO THE TERMS OF THE POLICY, WE WILL PAY THESE VOLUNTEERS ONLY FOR THE COVERED MEDICAL EXPENSES THAT ARE NOT WITHIN THE SCOPE OF THE INDIANA WORKERS' COMPENSATION AND WORKERS' OCCUPATIONAL DISEASES ACTS.

FRAUD NOTICE: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

NOTE: PLEASE READ THIS BEFORE SUBMITTING CLAIM

All questions must be answered in full for us to process the claim.

-INSTRUCTIONS-

WHEN TO FILE A CLAIM

1. Written notice of claim should be given to us within 180 days after a loss starts.
2. Written proof of loss (completed claim form and supporting documents) should be given to us within 90 days after the loss starts.

HOW TO FILE A CLAIM

1. The Patient (parent or guardian, if minor) must complete the Patient's section (SECTION I) in full.
2. Completion of the assignment section (SECTION IV) is optional.
3. The Volunteer Group Certification sections (SECTION V) must be completed and certified by an official of the Volunteer Group. **It is very important that the policy number be shown.**
4. **IF THE CLAIM IS FOR MEDICAL EXPENSE BENEFITS:**
   a) If the Patient is not a volunteer firefighter or volunteer EMT of a volunteer fire company – Please attach itemized bills showing the: (i) name of patient,(ii) diagnosed condition, (iii) date(s) of treatment, (iv) nature of treatment, and (v) charge per treatment as well as the copies of the denial(s).
   b) If the Patient is a volunteer firefighter or a volunteer EMT of a volunteer fire company and some of the medical expenses are denied by our insurance carrier under the Indiana Workers' Compensation or Workers' Occupational Diseases Act - Please attach itemized bills showing the: (i) name of patient,(ii) diagnosed condition, (iii) date(s) of treatment, (iv) nature of treatment, and (v) charge per treatment as well as copies of the denial(s).

WHERE TO FILE A CLAIM OR FOR ANY QUESTIONS

K&K Insurance | Specialty Benefits, PO Box 2338, Fort Wayne, IN 46801 PHONE: 800-237-2917, option 1

<table>
<tr><th colspan="4">Section I – Must be completed by the claimant / patient</th></tr>
<tr><td colspan="4">1. Volunteer Group Name</td></tr>
<tr><td colspan="2">2. Patient Name</td><td>3. Birth Date</td><td>4. Social Security Number</td></tr>
<tr><td colspan="4">5. If the Patient is a minor, name of Patient's parent or guardian</td></tr>
<tr><td colspan="4">6. Patient Address (city, state, zip)</td></tr>
<tr><td colspan="4">7. Patient is a(n) ☐ Auxiliary Member ☐ Youth Member ☐ Volunteer Group Member</td></tr>
<tr><td colspan="2">8. Activity</td><td>9. Supervisor</td><td>10. Title</td></tr>
<tr><td rowspan="5">Complete if accident and/or disability (including smoke inhalation) is involved</td><td>11. Date of accident (mm/dd/yyyy)</td><td>Time of accident: ☐ AM ☐ PM</td><td>Dismemberment ☐ Plegia ☐ Fatality</td></tr>
<tr><td colspan="3">12. What injuries were received?</td></tr>
<tr><td colspan="3">13. Where did the accident take place?</td></tr>
<tr><td colspan="3">How did the accident take place? (Be specific, explain exactly what happened, use additional paper if needed)</td></tr>
<tr><td colspan="3">The accident occurred (check one) ☐ While taking part in the activity listed in item 8 above, or ☐ During direct travel to or from the activity referred to in item 8 above.</td></tr>
<tr><td rowspan="5">Complete if contagious or infectious disease (excluding the common cold) or heart or circulatory malfunction is involved (Volunteer Group Members Only)</td><td colspan="2">14. Date of activity (mm/dd/yyyy)</td><td>Time of accident: ☐ AM ☐ PM</td></tr>
<tr><td colspan="3">15. Nature of Disease or Malfunction:</td></tr>
<tr><td colspan="3">16. Describe how and where it was contracted:</td></tr>
<tr><td colspan="3">17. Date and Time that symptoms first appeared: ☐ AM ☐ PM</td></tr>
<tr><td colspan="3">18. Have you ever had the same condition or similar condition in the past? ☐ Yes ☐ No
If yes, date of last treatment (mm/dd/yyyy): Treated by/at: _____</td></tr>
</table>

NATIONWIDE LIFE INSURANCE COMPANY | NATIONAL CASUALTY COMPANY
CLAIM FORM (please print or type)

Section I – Must be completed by the claimant / patient, continued

19. Occupation _____

20. Duties of your occupation at the time of disability _____

21. Last day worked, prior to injury, disease or malfunction MM/DD/YYYY

Complete only if you are applying for weekly income disability benefits (Volunteer Group Members Only) Please complete Sections II and III

22. I was (have been) unable to work because of this disability starting on MM/DD/YYYY
23. I returned (will return) to work on MM/DD/YYYY

24. Is the insured covered by the Indiana Workers' Compensation and Workers' Occupational Diseases' Acts?
☐ Yes ☐ No If "Yes," and some medical expenses were denied by the insurer under these Acts, please submit copies of the expenses, both paid and denied as well as copies of the denial letter(s), for our consideration. If "No", and the insured is a volunteer firefighter or a volunteer EMT of a volunteer fire company, please explain why he or she is not covered by / under these Acts._____

_____

25. I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available regarding either: (a) benefits for which either I, or the minor child for whom I am either parent or guardian, may be entitled to for this claim, or (b) the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or the minor child for whom I am the parent or guardian; to give K&K Insurance, Fort Wayne, Indiana or it legal representatives, any and all such information. I AGREE that a photographic copy of this Authorization will be valid as the original. This authorization will remain valid for the term of coverage of the policy.

26. Date ____/_____/_____ 27. Signature of Patient X_____ 28. Phone ( ) _____

SECTION II TO BE COMPLETED IN FULL BY THE PATIENT'S DOCTOR Note: Applies only to Disability Benefits

1. Name of Patient	2. Date of Illness (first symptom) or Injury (accident)
3. Diagnosis or Symptoms:	
4. Date patient first consulted you for this condition: MM/DD/YYYY	5. Has the patient ever had the same or similar symptoms? ☐ Yes ☐ No
6. Date patient able to return to work: MM/DD/YYYY	7. Dates of total disability: From MM/DD/YYYY Through MM/DD/YYYY

8. Progress:
a) Has the patient: ☐ Recovered ☐ Improved ☐ Not Changed ☐ Retrogressed
b) Is the patient: ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

9. Prognosis:

	His / Her Job?	**Any Job*?**
a) is the patient now capable of performing	☐ Yes ☐ No	☐ Yes ☐ No
b) what duties of his/her job is the patient incapable of performing?	_____	
c) Do you expect a fundamental or marked change in the future?	☐ Yes ☐ No	☐ Yes ☐ No
1) If yes, the patient should recover sufficiently to perform duties on or about	MM/DD/YYYY	MM/DD/YYYY

2) If no, please explain _____

*for which he or she is reasonably suited or qualified by education, training, or experience

_____ _____ ( ) _____
Doctor's Name Degree Telephone Number

_____ _____ _____ _____
Street Address City or Town State Zip

_____/_____/_____ _____
Date Signature

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SECTION III TO BE COMPLETED IN FULL BY THE PATIENT'S EMPLOYER		
1. Name of Employee	2. Social Security Number	
3. Employee Hire Date	4. Last Day Worked	
5. Reason for stopping work	6. Returned to work on:	7. Occupation at time of disability
8. Work schedule at the time of disability	Days per week	Hours per day

Employer _____ Address _____

Date ____/___/_____ Signed _____ Title_____ Tel No ( )_____

SECTION IV ASSIGNMENT OF MEDICAL EXPENSE BENEFITS

I Authorize K&K Insurance | Specialty Benefits to pay medical expense benefits in connection with this claim directly to the doctor, hospital, or other supplier.

1. Date ____/_____/_____ 2. Signature of Patient _____
(Parent or Guardian, if minor)

SECTION V VOLUNTEER GROUP CERTIFICATION

I certify that the above information is correct to the best of my knowledge and belief, that the person named in item 2 is insured by the policy, and that his or her insurance was in effect on the date of the covered activity involved.

1. Date ___/_____/_____ 2. Signed X_____ 3. Title _____

4. Policy Number _____	5. Phone ( ) _____

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NATIONWIDE LIFE INSURANCE COMPANY | NATIONAL CASUALTY COMPANY
CLAIM FORM (please print or type)

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Nationwide Life Insurance Company and Nationwide Mutual Insurance Company and National Casualty Company (collectively referred to as "Nationwide") are required by law to maintain the privacy of our members' health information. Unless you have signed a form authorizing the use or disclosure, we will not use or disclose your health information for any purpose other than Nationwide's role in treatment, payment or for health care operations. With your written approval, we may disclose your health information to others, including designated family, friends, or others who are involved in your health care or in payment for your health care. This form allows you to designate this/these person(s). A copy of this form is as valid as the original.

I understand that I am not required to sign this authorization form and that Nationwide will not condition coverage or the provision of payment to me on the signing of this authorization.

A SEPARATE FORM MUST BE COMPLETED FOR EACH ELIGIBLE PERSON. **This form can be copied if additional forms are needed.**

I, _____, hereby authorize the use or disclosure of health information about me as described below. (Instructions for above: print eligible person's name if over age 17, or if age 17 or under, the eligible person's parent or personal representative.)

As parent or personal representative, I authorize the use or disclosure of health information about the eligible person who is age 17 and under, as described below.

1. Person(s) or group of persons authorized to disclose the information:
   - Nationwide

2. Person(s) or group of persons authorized to receive and use the information from Nationwide.

Family and friends: check all that apply if you wish a family member or friend to be able to discuss your coverage and claims with Nationwide, and to receive health information which Nationwide maintains about you:

☐ Spouse (write in name and address): _____
_____

☐ Family member (write in name and address): _____
_____
Explain relationship: _____

☐ Friend(s) or Other(s) (write in name and address): _____
_____
Explain relationship: _____

3. Description of the information that may be used or disclosed:
   - All health information pertaining to me or my minor dependent(s) or the eligible person, if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition and any other policy related information.

4. I Understand that if the person or entity that receives the information described herein is not a health care provider or health plan covered by federal privacy regulations, the information described here may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

5. If the person completing this authorization is the personal representative of the eligible person or dependent, describe your authority to act on this person's behalf.

6. As described in the Notice of Privacy Practices I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Nationwide in reliance on this authorization by sending a written signed and dated revocation to K&K Insurance | Specialty Benefits, PO Box 2338, Fort Wayne IN 46801. A copy of the Notice of Privacy Practices is also available upon request at this address.

7. I understand that either my personal representative or I may receive a copy of this authorization upon request and that I may inspect or copy the information to be used or disclosed.

8. This authorization will expire 36 months after the policy termination date.

   Eligible Person Signature _____ Date: _____

   Personal Representative Name, if applicable _____
   (As described above in #5)

   Personal Representative Signature _____ Date: _____

Return form to: **K&K Insurance|Specialty Benefits, PO Box 2338, Fort Wayne IN 46801**

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Nationwide Life Insurance Company and Nationwide Mutual Insurance Company and National Casualty Company (collectively referred to as "Nationwide") are required by law to maintain the privacy of our members' health information. Unless you have signed a form authorizing the use or disclosure, we will not use or disclose your health information for any purpose other than Nationwide's role in treatment, payment or for health care operations. With your written approval, we may disclose your health information to others, including designated family, friends, or others who are involved in your health care or in payment for your health care. This form allows you to designate this/these person(s). A copy of this form is as valid as the original.

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As parent or personal representative, I authorize the use or disclosure of health information about the eligible person who is age 17 and under, as described below.

9. Person(s) or group of persons authorized to disclose the information:
   - Nationwide

10. Person(s) or group of persons authorized to receive and use the information from Nationwide.

Family and friends: check all that apply if you wish a family member or friend to be able to discuss your coverage and claims with Nationwide, and to receive health information which Nationwide maintains about you:

☐ Spouse (write in name and address): _____
_____

☐ Family member (write in name and address): _____
_____
Explain relationship: _____

☐ Friend(s) or Other(s) (write in name and address): _____
_____
Explain relationship: _____

11. Description of the information that may be used or disclosed:
    - All health information pertaining to me or my minor dependent(s) or the eligible person, if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition and any other policy related information.

12. I Understand that if the person or entity that receives the information described herein is not a health care provider or health plan covered by federal privacy regulations, the information described here may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

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17. Eligible Person Signature _____ Date: _____

    Personal Representative Name, if applicable _____
    (As described above in #5)

    Personal Representative Signature _____ Date: _____

Return form to: **K&K Insurance|Specialty Benefits, PO Box 2338, Fort Wayne IN 46801**

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