Universal Claim Form

Fax this form: 1-972-726-6028 or **mail to P.O. Box 809043, Dallas, TX 75380**

From:

Fax documents in this direction

Number of pages:

File Your Claim Online

- Simply visit NFCBenefits.com and submit the forms
- As an added benefit you may also email your claim information to claims@nfclife.com

Clear Form

Claimant Information

Claimant Name: _____ Date of Birth: ____/____/____

Phone Number: _____ Policy Number(s): _____

Fraud Warning: For your protection, Any person who knowingly and with the intent to injure, defraud or deceive an insurance company 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.

Please check the type(s) of claim you are filing

☐ **Accident**, **Accident Sickness & Recovery:** Provide a description of the accident. Include a copy of the Admissions and Discharge Summary and itemized copies of any related medical bills. Please include the attached Physician Statement (completed by your medical provider).

☐ **Cancer, Cancer OP:** Include a copy of the Pathology Report along with the Admissions and Discharge Summary. Please include the attached Physician Statement (completed by your medical provider)

☐ **Critical Illness:** Include Admissions and Discharge Summary and all medical information related to the illness. Please include the attached Physician Statement (completed by your medical provider).

☐ **Emergency Room:** Include a copy of the itemized bill showing date(s) and treatment(s). Please include the attached Physician Statement (completed by your medical provider).

☐ **Hospital Indemnity, Intensive Care, Outpatient Surgery** (Includes **Heart Attack** and **HIP Rider**): Include a copy of the Admission And Discharge Summary, the itemized Hospital Statement along with EKG / Cath Reports. For outpatient surgery; Include a copy of the itemized surgeon's bill showing the diagnostic / procedure codes and a copy of the operative report. Please include the attached Physician Statement (completed by your medical provider).

All sections of the claim form must be completed in their entirety to ensure quicker processing. Along with your claim, please submit a copy of the information requested. Incomplete claim form submission may result in a delay in the processing of your claim.

Every claim requires the completion of a Medical Release Authorization Form (for HIPAA compliance). This HIPAA form provides permission for your health care provider to disclose personal information about you and, if applicable, the dependents on your policy.

You will be notified should additional information be required.

Please provide all information requested

☐ Accident ☐ Cancer ☐ Critical Illness ☐ Emergency Room ☐ Hospital Indemnity / Outpatient Surgery

Claimants Statement (completed by the policy owner)

Claimant Name: _____ Policy Number(s): _____

Claimant Phone: _____ Relationship to Policy Owner: _____ Claimant SSN: _____

Claimant DOB: ___/___/___ Claimant Gender: _____ Claimants Email:

Policy owner: _____ Policy Owner SSN: _____

Address: _____ Phone: _____ Policy Owner DOB: ___/___/___

City: _____ State: _____ Zip: _____ Email: _____

Accidental Injury: (completed by policy owner)

Date of Accident ___/___/___

Have you been treated for the same or similar condition prior to this occurrence? ☐ Yes ☐ No
If yes, when? _____

Emergency room treatment only: ☐ Yes ☐ No If yes, date of emergency room treatment ___/___/___

Hospital Admission and Discharge

Hospital Name: _____ Date Admitted: _____

Address: _____ City: _____ State: ___ Zip: ___ Date Released: _____

Hospital Name: _____ Date Admitted: _____

Address: _____ City: _____ State: ___ Zip: ___ Date Released: _____

TREATMENT INFORMATION DESCRIBE WHAT KIND OF TREATMENT YOU HAVE RECEIVED (Medical and/or Surgical) with DATES:

COMMENTS PLEASE SUPPLY ANY ADDITIONAL INFORMATION THAT WILL ASSIST US IN PROCESSING YOUR CLAIM:

Fraud Warning: For your protection, Any person who knowingly and with the intent to injure, defraud or deceive an insurance company 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.

Fraud Notice: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes the Physician Statement portion of the claim form.

Certification

Policy owner's name: _____ SSN: _____

I have checked the answers on this claim form, and they are correct. I certify under penalty of perjury that my correct Social Security Number is shown on this form. I acknowledge that I received the Claim Fraud Statements on page two of this form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form.

Print claimant's name	Claimant's signature	Date MM/DD/YYYY
Print policy owner's name	Policy owner's signature	Date MM/DD/YYYY

Clear Form