KEMPER
Home Service Companies

YOUR REPORT OF INJURY

Policy Number: _____ **Name of Insured:** _____

HOW TO SUBMIT YOUR CLAIM:

1. You should answer, in detail, questions on this side of the form and sign. If you know your Policy Number, please list it.
2. If treatment for the injured party wasn't received at a Hospital or Urgent Care Facility, your Physician must complete Part B of this form.
3. The back side of this form should be completed and signed.
4. Submit the itemized bill, discharge form, or summary of services rendered from your Provider for the treatment of the injury.

PART A (PLEASE PRINT)

Name of Injured Party		Date of Birth
Address		Telephone
City	State	Zip
Please describe the injury, including the date.		

I affirm that the above information is true and correct.

Any person who knowingly prepares or presents to an insurer a statement that contains false or misleading material information in support of a claim under an insurance policy, with intent to defraud the insurer, may be guilty of a crime and subject to fines and confinement in state prison.

_____

Signature of injured party or legal guardian of injured party if injured party is a minor — Date

_____

Signature of Named Insured — Date

PART B - CERTIFICATION OF EMERGENCY CARE

Patient Name: _____ Patient Date of Birth: _____

I certify that I am a Physician* and that I (or another Physician* working in collaboration with me) had an encounter with this patient in a hospital emergency room, in an outpatient facility or in a Physician's office during which this patient's medical condition was addressed on (Month/Day/Year): _____

The following clinical findings were made on this date:

_____

_____

I certify that this patient's medical condition addressed on this date required Emergency Medical Care, defined as bona fide emergency services provided after sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part.

Any person who knowingly prepares or presents to an insurer a statement that contains false or misleading material information in support of a claim under an insurance policy, with intent to defraud the insurer, may be guilty of a crime and subject to fines and confinement in state prison.

Physician Signature _____ Physician Printed Name _____

Physician Address _____ Date: _____

*For this purpose, a Physician is a person who: (a) is a legally qualified practitioner of the healing arts in the jurisdiction in which he/she practices; (b) practices within the scope of his/her license; (c) is not related to the above-named Insured or patient; and (d) does not live in the same household as the above-named Insured or patient.

Authorization to Disclose/Release Confidential Medical Information

Records and information obtained will be disclosed to The Reliable Life Insurance Co. (the "Company"). The purpose of this disclosure is to evaluate a claim of insurance benefits for the patient listed below.

I authorize any health plan, licensed physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit provider, pharmacy related service organization, medical facility, or other health care provider, insurance support organizations, insurance company, consumer reporting agency, or other organization, institution or person that has any records or knowledge of:

Patient Name: _____ Date of Birth: _____

Complete Address: _____

to disclose transaction records, employment records, financial records, the entire medical record and any other protected health information concerning the proposed insured to the above Company, their licensed representatives and/ or their reinsurers, Examination Management Services, Inc., CoventBridge Group, or if other, indicate here: _____. This includes any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition. Such records and information may include, but not be limited to: alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, lab data and EKG's, 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.

I understand that the information obtained may be used by the Company to administer benefit payments. The Company may not give the information to any person or entity except: 1) a reinsurer, or other insurers to whom I have applied or may apply; 2) any other person or entity who performs business or legal services in connection with the administration of my insurance coverage. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. Information may be disclosed as allowed by law or regulation.

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 may revoke this consent in writing at any time by sending written notification to: Kemper Home Service Companies, Life Claims Dept., 1350 Timberlake Manor Parkway, Suite 200, Chesterfield, MO 63017-6039. I understand that a revocation is not effective if the Company has taken action in reliance on this Authorization.

I understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to make any benefit payments.

As used in this Agreement and Authorization, the words "I" or "my" refer to the Claimant named above.

Date:_____ _____

Signature of Claimant

Claimant's relationship to patient/decedent: _____