Ullico
SOLUTIONS FOR THE UNION WORKPLACE

COMA/BRAIN INJURY CLAIM FORM

STATEMENT OF CLAIM

PLEASE PRINT

Please submit this form to:
GROUP LIFE CLAIM DEPARTMENT
The Union Labor Life Insurance Company

8403 Colesville Road • Silver Spring, MD 20910
Toll-free (8660 795-0680 • Fax: (202) 962-2939

TO BE COMPLETED BY POLICYHOLDER

Name of policyholder: _____

Group policy number: _____ Amount of insurance: $ _____

This is to certify that the insured named below was eligible for benefits on the date the accident occurred. I acknowledge that I have read the fraud warning(s) on page 4 of this form.

Signature of Policyholder's Representative: X _____ Date: _____
Signature and title

INSURED STATEMENT

Insured's name: _____

Date of birth: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Last day worked: _____

Date of accident: _____ Place of Accident: _____

Cause and circumstances of accident. (Brief explanation of how it happened.) Attach police report, newspaper articles or similar documents.

_____

_____

_____

Print name: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Claimant / Insured of personal / legal representative signing for Claimant / Insured: _____

I hereby certify that the answers I have made to the questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud warning(s) on page 4 of this form.

Signature: X _____ Date: _____

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Please submit this form to:
GROUP LIFE CLAIM DEPARTMENT
The Union Labor Life Insurance Company

8403 Colesville Road • Silver Spring, MD 20910
Phone: (202) 682-6768 • Fax: (202) 962-2939
Toll-free: (866) 795-0680

AUTHORIZATION FOR RELEASE OF INFORMATION

1. I (the undersigned) authorize any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; insurance or reinsurance company; government agency; department of labor; law enforcement or public safety department; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

Claimant/Insured name: _____
Last First Middle

Date of birth: _____ SSN: _____

Claimant/Insured Information to be released:

- Data or records regarding medical history, treatment, prescriptions, consultations, (including medical and psychological reports, records, charts, notes [excluding psychotherapy notes], x-rays, films or correspondence, and any medical conditions(s)):
- Any information regarding insurance coverage; and
- Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).

Information to be released to: The Union Labor Life Insurance Company Attn: Group Life Claim Department, 8403 Colesville Road, Silver Spring, MD 20910

I understand the information obtained by use of this Authorization will be used by The Union Labor Life Insurance Company ("Company") to evaluate my claim for Coma/Brain Injury Benefits. The Company will only release such information:

- to its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
- as otherwise may be required by law or as I may further authorize.

I further understand that refusal to sign this Authorization may result in the denial of benefits.

I understand the information used to disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law. For Colorado claims, the disclosed information may not be redisclosed or reused by the recipient under Colorado law.

I understand that I may revoke this Authorization in writing at any time, except to the extent:

1) the Company has taken action in reliance on this Authorization; or
2) the Company is using this Authorization in connection with a contestable claim. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of my signature below. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.

A photocopy of this Authorization is to be considered as valid as the original.

I understand I am entitled to receive a copy of this Authorization.

Legal Representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/insured is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

Signature: X _____ Date: _____

PLEASE COMPLETE ALL PAGES

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ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

Insured's name:_____ SSN: _____

TO THE DOCTOR: Please complete the following questions regarding the Coma/Brain Injury claim for the above named patient.

When did symptoms first appear/accident happen? _____

DIAGNOSIS:

_____

_____

_____

Date coma / brain injury began:_____ Has the patient been in a continuous coma? _____

Duration of the coma / brain injury: _____

Nature of treatment: _____

_____

_____

_____

_____

Prognosis for recovery: _____

_____

_____

_____

Hospital confinement dates: _____

Name of hospital: _____

Address:_____ City:_____ State:_____ Zip: _____

Print physician name: _____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Specialty/Degree: _____

Physician's signature: X_____ Date: _____

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FRAUD NOTICES

Arkansas: 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.

California: For your protection California Law requires the following to appear on this form: Any person who knowingly presents 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.

Colorado: 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.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

Louisiana: 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.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 Mexico: 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 CRIMINAL PENALTIES.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: 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.

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: 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.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.

I attest that I have reviewed, understand and acknowledge the fraud warning(s).

_____

Member or Claimant's Signature Date

PLEASE COMPLETE ALL PAGES