COMBINED INSURANCE®

Administered By:
Vision Financial Corporation
17 Church Street, P.O. Box 506
Keene, NH 03431-0506
Telephone: (855) 241-9891 Option 2

Employer's/Business Entity's Statement			
1. Name of Employee/Insured Person	2. Social Security No.	3. Date of Birth	
4. Phone No.	5. Group No.	6. Occupation	
7. Employee's/Insured Person's Street Address	8. City	9. State	10. Zip Code
11. Employer/Business Entity	12. Employer/Business Entity Phone No.	13. Duties	
14. Employer's/Business Entity's Street Address	15. City	16. State	17. Zip Code

Signed in (City/State)_____This_____Day of (Month/Year) _____

_____ _____ _____

Name of Company Signature Official Position

Claimant's Statement

□ Home Health □ Adult Day Care □ Assisted Living □ Other _____

1. Policyholder	2. Policyholder's Social Security No.	3. Policy No.	
4. Patient's Name	5. Patient's Social Security No.	6. Phone No.	
7. Street Address	8. City	9. State	10. Zip Code

11. Type of Residence: □ Home □ Apartment □ Retirement Community □ Other _____

12. Describe condition for which claim is being made

13. Name of Attending Physician	14. Phone No.		
15. Street Address	16. City	17. State	18. Zip Code
19. Name of Hospital	20. Date Admitted	21. Date Discharged	
22. Street Address	23. City	24. State	25. Zip Code

Name, address and telephone number of person assisting with claim (if any)

26. Name	27. Relationship	28. Phone No.	
29. Street Address	30. City	31. State	32. Zip Code

Attach a copy of Legal Instrument. Check One: □ Power of Attorney □ Guardianship

Patient or Personal Representative's Signature _____Date _____

Assessment Form

To be completed by Case Manager, Social Security Worker, Registered Nurse or Physician

1. Patient Name	2. Date of Birth

3. Diagnosis and Concurrent Condition

1 2.

3. 4.

5. 6.

4. Date symptom first appeared?	5. Date patient first consulted you for this condition?
6. Has Patient ever had same condition □ Yes □ No	7. Is Patient still under your care for this condition?
8. Was Patient Hospitalized? □ Yes □ No From To	9. Was Patient in a Nursing Home Facility? □ Yes □ No
10. Period Authorization for this condition From To	11. Medicare Coverage □ Yes □ No

12. The above listed patient requires care to perform the following Activities of Daily Living or Instrumental Activities of Daily Living. I= Independent S=Stand-by Assistance at Arm's Length O=Needs Hands-On to Perform

ADL	I	S	O		**IADL**	I	S	O
a. Bathing					h. Medicine Admin			
b. Dressing					i. Personal Financial			
c. Toileting					j. Prepare/Cook Meals			
d. Continence					k. Use Telephone			
e. Mobility					l. Housework			
f. Transfers					m. Laundry			
g. Feeding/Eating								

9. Cognitive Impairment: □ Yes □ No (If "Yes", attached Clinical Test/Documentation)

10. I hereby certify that the above listed patient will be chronically ill for a period of 90 days or more: □ Yes □ No

11. Patient Requires: □ Home Health Care □ Adult Day Care □ Hospice Program □ Respite Care □ Assisted Living Facility

12. Recommended Services: □ Nurse □ Therapist □ Homemaker □ Companion □ Other

13. Total Number of Days Per Week:	14. Number of Hours Per Day:	15. Where is care being provided? [] Home [] Apartment [] Retirement Community [] Facility [] Other

16. Name of Provider:	17. Tax ID/Social Security No.:	18. Phone No.:

19. Street Address:	20. City:	21. State:	22. Zip Code:

23. Type of License: □ Heath Care Agency Care □ Adult Day Care □ Hospice Program □ Other

24. Print Name:	25. Degree:	26. Phone No.:	
27. Street Address:	28. City:	29. State:	30. Zip Code:

Signature_____ Date_____

Attach the following documents:

1) Plan of Care
2) Itemized Billing Statement
3) Explanation of Medicare Benefit Statements (if Medicare coverage on these services)

REQUIRED FRAUD WARNING STATEMENTS

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below. Sign, date, and return with claim documents.

FOR RESIDENTS OF ALASKA or TEXAS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, or misleading information may be prosecuted under state law.

Claimant's signature Date

FOR RESIDENTS OF ARIZONA: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Claimant's signature Date

FOR RESIDENTS OF CALIFORNIA: For your protection California law requires the following to appear on this form. Any person who knowingly presents a 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.

Claimant's signature Date

FOR RESIDENTS OF 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 the insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Claimant's signature Date

FOR RESIDENTS OF DELAWARE, IDAHO or INDIANA: 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.

Claimant's signature Date

FOR RESIDENTS OF 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.

Claimant's signature Date

FOR RESIDENTS OF HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Claimant's signature Date

FOR RESIDENTS OF 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.

Claimant's signature Date

FOR RESIDENTS OF 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.

Claimant's signature Date

FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.

Claimant's signature Date

FOR RESIDENTS OF 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 by RSA 638:20.

Claimant's signature Date

FOR RESIDENTS OF NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Claimant's signature Date

FOR RESIDENTS OF OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Claimant's signature Date

FOR RESIDENTS OF PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Claimant's signature Date

FOR RESIDENTS OF VIRGINIA, TENNESSEE, MAINE, or DISTRICT OF COLUMBIA: 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.

Claimant's signature Date

FOR RESIDENTS OF ALL OTHER STATES: Any person who knowingly, and with intent to injure, defraud or deceive 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.

Claimant's signature Date

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AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

1. Person(s) or group(s) of persons authorized to use and/or disclose the information: Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.
2. Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information: the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.
3. Description of the information that may be used or disclosed: This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or information regarding AIDS. Exception: psychotherapy notes require a separate signed authorization.
4. The information will be used or disclosed only for the following purpose(s): The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.
- I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).
- I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosers of my health information for purposes of treatment, payment or health care operations.
- This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy.
- A copy of this authorization will be considered as valid as the original.
- I acknowledge that I have received a copy of this authorization.

Patient Insured's Name/Signature _____ Date _____

Patient Insured's SSN _____ Patient Insured's Date of Birth _____ Patient Insured's Phone No. _____

Patient Insured's Address _____

Personal Representative's (if any) Name/Signature: _____ Personal Representative's Phone No. _____

Personal Representative's (if any) Address _____

Description of Personal Representative's Authority or Relationship to Patient Insured _____

Policy or Contract Number _____

Claimants should retain a copy of this signed document for their records.