Nippon Life Benefits®

Medical Claim

Please mail completed form to:
Nippon Life Benefits
P.O. Box 4387
Clinton, IA 52733
Toll Free: 1-800-374-1835

- **Most** claims are filed by doctors and hospitals and you may not need a form. If your doctor or hospital requires one, complete this form and send it to the address on your ID card. Sending it to the home office of Nippon Life Insurance Company of America will delay processing. For information about a claim, please call the toll-free claim center number of your ID Card.
- Please provide information as indicated to avoid delay in the processing of this claim.
- For verification of coverage, the provider should call Nippon Life Insurance Company of America toll free nationwide at **1-800-374-1835**.

Part A. Employee Information

Employee's name (first, middle, last) | **Group and I.D. numbers (printed on I.D. card)** Group I.D. | Employee's birth date

Employee's employer | Employee's employment date | Is employee still working? ☐ yes ☐ no | If "no," give date last worked

Is employee
☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Part B. Patient Information (Complete a separate form for each patient.)

For whose expenses is claim being made? (If patient is other than self, answer questions 1-8 in this section.)
☐ self (If "self," go to questions 4, 5, 6, 7, 8) ☐ Wife ☐ husband ☐ stepchild ☐ Son ☐ daughter ☐ foster child

1. Patient's birth date | 2. Patient's name (first, middle, last)

3. Patient's occupation

4. This claim is the result of ☐ illness ☐ injury | 5. Is it employment related? ☐ yes ☐ no | 6. Date occurred | 7. If injury, place it happened

8. Describe illness/injury

Part C. Other Insurance Information

(Complete if: • this is the first claim for this illness or injury - **or** – • you have not submitted a completed claim form in the last six months.)

If employee is married, give spouse's name (if other than patient) | Spouse's birth date (if other than patient) | Spouse's social security number

Is spouse employed? ☐ yes ☐ no | If "yes," give name, address and telephone number of spouse's employer.

If "yes," does spouse's employer provide group medical coverage? ☐ yes ☐ no | If "yes," please list any family members covered by this plan?

If "no," please explain

If patient is covered by spouse's plan or any other medical plan, group policy, prepayment plan, Medicare or other government plan, please provide the following information:

Name of person(s) carrying the other coverage | Name of group (employer, association, etc.)

Group number | Name and address of insurance company or plan

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. Applicable to Accident and Health.

I have read the notice requirements on Page 2 of this form.

These statements are true and complete to the best of my knowledge.

▶ Signature of employee | Date signed

Print

Part D. Authorization for Release of Information (Complete for every claim.)

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Nippon Life Insurance Company of America (Nippon Life Benefits) and the planholder, or their representatives, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization.

▶ Signature of employee | Date signed

▶ Signature of patient (required if patient is spouse) | Date signed

Address of employee (street) | (city)

(state) | (ZIP code) | Is this a new address? ☐ yes ☐ no | Please furnish a daytime telephone number in case we need to reach you.

Medical Claim Form

Authorization to Pay (Sign here only if you want benefits paid directly to patient's doctor, hospital, or other provider of medical care.)

I authorize payment of medical benefits to physician or supplier for service described below or on attached bill.

▶ Signature of authorized person | Date signed

In order for this claim to be processed accurately an itemized statement must be attached. An itemized statement must include the provider's name and address, dates and types of services, charges, patient's name and diagnosis.

Notice Requirements

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form containing any materially false information or who conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

INDIANA: 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.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

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

OHIO: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

TEXAS: 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.