CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427, Columbia, South Carolina 29202
Phone (866) 849-0011 Fax (866) 849-2970

Hospital Indemnity Claim Form

Instructions

1. Please complete the claim form below in its entirety (if information is missing, it may delay the processing of your claim).
2. Be sure to sign and date the authorization and claim form.
3. Provide the dates hospitalized and a description of your accident or onset of illness.
4. Provide the discharge summary and itemized hospital bill with admission and discharge dates, diagnosis code, and room and board charges.

PART A — CERTIFICATEHOLDER/CLAIMANT'S STATEMENT

1	EMPLOYER'S NAME		CERTIFICATEHOLDER'S E-MAIL ADDRESS		
2	CERTIFICATEHOLDER'S NAME	CERTIFICATE NO.	SOCIAL SECURITY/ *ID #:*	DATE OF BIRTH	GENDER
3	CERTIFICATEHOLDER'S ADDRESS STREET		CITY	STATE	ZIP CODE
4	CLAIMANT'S NAME (PERSON WHO IS SICK OR INJURED)	DATE OF BIRTH	RELATIONSHIP TO CERTIFICATEHOLDER	CERTIFICATEHOLDER'S TELEPHONE NO. (WITH AREA CODE)	
5	DESCRIBE WHEN AND HOW YOUR ACCIDENT OCCURRED OR THE ONSET AND NATURE OF YOUR ILLNESS.				

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DATE(S) HOSPITALIZED

DOCTOR TREATED OR REFERRED BY :

DATE	NAME	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.

HOSPITALIZED:

DATE	NAME	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.

AUTHORIZATION

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Several states require that the following statement appear on the claim forms:
Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included with this form.

Certificateholder's Signature: _____ Date: _____

Claimant's Signature: _____ Date: _____