NATIONWIDE LIFE INSURANCE COMPANY
NATIONAL CASUALTY COMPANY
CLAIM FORM (please print or type)
GROUP INSURANCE
Submit to: Nationwide Specialty Insurance, PO Box 420, Springfield, MA 01101

SECTION I: TO BE COMPLETED IN FULL BY THE PLAN SPONSOR ORGANIZATION. Plan Sponsor Signature required ***(You may submit proof of membership or Certificate of Coverage in place of Plan Sponsor signature)***

1. Policy Nbr________________________ 2. Name of Plan Sponsor Organization ____
Group's Name

3. Name of Patient ____ 4. Sex ❑ M ❑ F 5. School Grade ____________

6. Address of Patient____
Street City State Zip

COMPLETE IF ACCIDENT IS INVOLVED	7. Date and Time of Accident: ______/______/______ Time _____________ ❑ AM ❑ PM ❑ DISMEMBERMENT/PLEGIA ❑ FATALITY 8. **WHAT** injuries were received? ____ 9. **WHERE** did the accident take place? ____ 10. **HOW** did the accident take place? *(be specific, explain exactly what happened)*______________ ____ 11. Did the accident occur: ❑ While taking part in an activity sponsored and directly supervised by the plan sponsor. Describe type of activity involved ____ Name of Supervisor___________________________________ Title ______________________ Phone (______) _______________ ❑ During direct travel to or from the meeting place to take part in a Patient activity.
COMPLETE IF SICKNESS IS INVOLVED	12. Nature of sickness____ 13. Date symptom first appeared ______/______/______ 14. Date of first expense resulting from the sickness ______/______/______

I certify that the above information is correct to the best of my knowledge and belief, that the person named in item 3 is insured by the policy, and that his or her insurance was in effect on the date the accident or sickness occurred. The signature can not be by the Patient, a Patient's spouse, son, daughter, father, mother, brother or sister, other relative or agent.

Signature of Plan Sponsor____ Date ______/______/______

Title ____ Phone (______) ____________

SECTION II: TO BE COMPLETED BY THE PATIENT (PARENT OR GUARDIAN, IF MINOR)

15. Patient's Name ____ 16. Date of Birth ______/______/______

17. Social Security Number _______/_______/___________

18. Patient's Employer/Address ____

I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available regarding either: (a) benefits for which either I, or the minor child for whom I am either parent or guardian, may be entitled to for this claim, or (b) the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or the minor child for whom I am the parent or guardian; to give NATIONWIDE SPECIALTY INSURANCE CLAIMS, Columbus, Ohio, or it's legal representatives, any and all such information. I AGREE that a photographic copy of this Authorization will be valid as the original. This authorization will remain valid for the term of coverage of the policy.

Signature of Patient ____ Date ______/______/______
(Parent or Guardian, if minor) Phone (______) ______________

SECTION III: ASSIGNMENT OF BENEFITS

I AUTHORIZE Nationwide Specialty Health Claims, Columbus, Ohio, to pay benefits in connection with this claim directly to the

doctor, hospital, or other supplier.

Signature of Patient ____ Date ______/______/______
(Parent or Guardian, if minor)

Nationwide®
On Your Side℠

NATIONWIDE MUTUAL INSURANCE COMPANY
NATIONWIDE LIFE INSURANCE COMPANY
NATIONAL CASUALTY COMPANY

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Nationwide Life Insurance Company and Nationwide Mutual Insurance Company and National Casualty Company (collectively referred to as "Nationwide") are required by law to maintain the privacy of our members' health information. Unless you have signed a form authorizing the use or disclosure, we will not use or disclose your health information for any purpose other than Nationwide's role in treatment, payment or for health care operations. With your written approval, we may disclose your health information to others, including designated family, friends, or others who are involved in your health care or in payment for your health care. This form allows you to designate this/these person(s). A copy of this form is as valid as the original.

I understand that I am not required to sign this authorization form and that Nationwide will not condition coverage or the provision of payment to me on the signing of this authorization.

A SEPARATE FORM MUST BE COMPLETED FOR EACH ELIGIBLE PERSON. This form can be copied if additional forms are needed.

I, __________________________, hereby authorize the use or disclosure of health information about me as described below. (Instructions for above: print eligible person's name if over age 17, or if age 17 or under, the eligible person's parent or personal representative.)

As parent or personal representative, I authorize the use or disclosure of health information about the eligible person who is age 17 and under, as described below.

1. Person(s) or group of persons authorized to disclose the information:

- Nationwide

2. Person(s) or group of persons authorized to receive and use the information from Nationwide.

Family and friends: check all that apply if you wish a family member or friend to be able to discuss your coverage and claims with Nationwide, and to receive health information which Nationwide maintains about you:

☐ Spouse (write in name and address): ____
____

☐ Family member and relationship (write in name and address): ____
____

☐Friend(s) or Other(s) and relationship (write in name and address): ____
____

3. Description of the information that may be used or disclosed:

- All health information pertaining to me or my minor dependent(s) or the eligible person, if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition and any other policy related information.

4. I understand that if the person or entity that receives the information described herein is not a health care provider or health plan covered by federal privacy regulations, the information described here may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

5. If the person completing this authorization is the personal representative of the eligible person or dependent, describe your authority to act on this person's behalf. ____

6. As described in the Notice of Privacy Practices I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Nationwide in reliance on this authorization by sending a written signed and dated revocation to Nationwide Specialty Health, P0 Box 2399, Mail Code CO-01-26, Columbus, OH 43216-2399. A copy of the Notice of Privacy Practices is also available upon request at this address.

7. I understand that either my personal representative or I may receive a copy of this authorization upon request and that I may inspect or copy the information to be used or disclosed.

8. This authorization will expire 36 months after the policy termination date.

Eligible Person Signature ____ Date: _____________________

Personal Representative Name, if applicable (As described above in #5)____

Personal Representative Signature ____ Date: _____________________

State Fraud Notices

(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.

(Alaska) A person who knowingly and with intent to injury, defraud, or deceive an insurance company files a claim containing, false, incomplete, or misleading information may be prosecuted under state law.

(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.

(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.

(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.

(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 benefits, if false information materially related to a claim was provided by the applicant.

(Delaware) 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.

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

(Idaho) Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

(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.

(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.

(Maine) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(Minnesota) A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.