



**CLAIM REPORT FOR
AMERICAN REPUBLIC INSURANCE COMPANY
NURSING HOME INDEMNITY POLICY**

Instructions: Be certain all questions on this side of the form are answered. The reverse side of this form is to be completed by your physician before it is returned to us.

1. Insured's statement	Name of Policyholder _____ Policy Number or I.D. Number _____ Name of Patient _____ Date of Birth _____ Address _____ City _____ State _____ Zip Code _____ Name of condition being treated? _____ If due to sickness, when did first symptoms appear? _____ If due to injury, give date of accident _____ Where and how did accident occur? _____ Do you have any other insurance or plan with any other company, plan, association or government association that provides benefits for nursing home care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give the following details: <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%; text-align: center;">Name of Company or Plan</th> <th style="width:33%; text-align: center;">Policy Numbers</th> <th style="width:33%; text-align: center;">Address of Company or Plan</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td>1. _____</td> <td>1. _____</td> </tr> <tr> <td>2. _____</td> <td>2. _____</td> <td>2. _____</td> </tr> <tr> <td>3. _____</td> <td>3. _____</td> <td>3. _____</td> </tr> </tbody> </table>	Name of Company or Plan	Policy Numbers	Address of Company or Plan	1. _____	1. _____	1. _____	2. _____	2. _____	2. _____	3. _____	3. _____	3. _____
Name of Company or Plan	Policy Numbers	Address of Company or Plan											
1. _____	1. _____	1. _____											
2. _____	2. _____	2. _____											
3. _____	3. _____	3. _____											
2. Please give name and address of your physician or any other doctors treating or who have treated this condition	1. Physician's Name _____ Address _____ City _____ State _____ Zip Code _____ 2. Physician's Name _____ Address _____ City _____ State _____ Zip Code _____ 3. Physician's Name _____ Address _____ City _____ State _____ Zip Code _____												
3. Please give name and address of health care facility	Name of Facility _____ Address _____ City _____ State _____ Zip Code _____ Date of Confinement _____												
4. Authorization to release information	<p>IMPORTANT! THE FOLLOWING AUTHORIZATION MUST BE COMPLETED BY BOTH THE PATIENT AND THE DOCTOR.</p> <p>I authorize any physician, hospital, medical practitioner, clinic, insurance company, insurer or other organization or institution or person having any records, data or information concerning me or any member of my family to furnish such records, data or information as may be requested by such company to American Republic Insurance Company or its duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; text-align: center;">_____ Signature of Policyholder</td> <td style="width:33%; text-align: center;">_____ Signature of Attending Physician</td> <td style="width:33%; text-align: center;">_____ Signature of Patient</td> </tr> <tr> <td style="text-align: center;">_____ Address of Policyholder</td> <td colspan="2" style="text-align: center;">_____ Address of Attending Physician</td> </tr> <tr> <td style="text-align: center;">_____ City State Zip Code</td> <td style="text-align: center;">_____ City State Zip Code</td> <td style="text-align: center;">_____ City State Zip Code</td> </tr> <tr> <td colspan="3" style="text-align: center;">_____ Date</td> </tr> </table> <p>The furnishing of forms does not constitute an admission of liability on the part of the Company.</p>	_____ Signature of Policyholder	_____ Signature of Attending Physician	_____ Signature of Patient	_____ Address of Policyholder	_____ Address of Attending Physician		_____ City State Zip Code	_____ City State Zip Code	_____ City State Zip Code	_____ Date		
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_____ Address of Policyholder	_____ Address of Attending Physician												
_____ City State Zip Code	_____ City State Zip Code	_____ City State Zip Code											
_____ Date													

5. Physician's statement	Patient's name _____ Diagnosis _____ If due to sickness, when did first symptoms appear? _____ If due to injury, give the date of accident _____ Has the patient ever suffered previously from the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ List any secondary condition(s) and/or complication(s) _____ Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name and address of referring physician _____ If the patient was hospitalized, indicate name and address of the hospital and dates of confinement _____ What is your prognosis for this patient? _____
6. Health care facility information and certification of medical necessity	Name and address of health care facility _____ How is the facility licensed? _____ What type of nursing care is the insured receiving? <input type="checkbox"/> Skilled <input type="checkbox"/> Intermediate <input type="checkbox"/> Custodial If the insured is in a skilled facility, do you certify the insured requires skilled nursing care? <input type="checkbox"/> Yes <input type="checkbox"/> No If the insured is in a custodial or intermediate facility, do you certify they require confinement for medically necessary nursing care other than skilled nursing care because of an injury or sickness? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Home health aide information	If the insured is receiving services from a home health aide, do you certify they require these services in lieu of nursing home confinement to meet daily living needs? _____ Name and address of home health aide _____

Attending Physician's Signature _____

Social Security Number _____

Federal Tax Number _____



American Republic Insurance Company
 National Headquarters, Des Moines, Iowa 50334