Kemper Home Service Companies

Indicate the company for which claim is being made:

- ☐ **UNITED INSURANCE COMPANY OF AMERICA**
- ☐ **THE RELIABLE LIFE INSURANCE COMPANY**
- ☐ **UNION NATIONAL LIFE INSURANCE COMPANY**
- ☐ **MUTUAL SAVINGS LIFE INSURANCE COMPANY**
- ☐ **ATLANTA LIFE INSURANCE COMPANY**

Policy No(s):_____

Name of person this form applies to:

_____

HOW TO SUBMIT YOUR CLAIM:

1. If your period of disability is expected to continue for some time, complete this report now, so that your claim can be started. Another form will be provided to you when needed.
2. You should answer, in detail, questions on this side of the page. If you know your Policy Number, please list it.
3. Take or mail this form to your doctor so that he can complete the back side, Attending Physician Statement. He should mail it to us at the address shown.
4. If you need any help or have any questions, call the district office shown on your premium receipt book.

YOUR REPORT OF DISABILITY

(TO BE COMPLETED BY INSURED)

Any person, who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

PART A (Please Print)

Your Name		SS Number
Address		
City	State	Zip Code
Policy Number	Date of Birth	Telephone No.

1. Please describe your sickness or accident. If accident, please provide date and description of the accident.		
2. Name, address, and telephone number of your employer.	Name	Telephone No.
	Address	City, State, and Zip Code
3. Have you been unable to work because of this condition? Yes ☐ No ☐	If "Yes" From:	To:

FOR CONTESTABLE CLAIMS ONLY (POLICIES LESS THAN 2 YEARS OLD)

List names of all hospitals and give location where any medical treatment or attention was received by you during the 2 year period prior to the issue date of your policy.

HOSPITAL	CITY	STATE	ZIP CODE
1.			
2.			

List names and addresses of all doctors who rendered medical treatment or attention to you during the 2 year period prior to the issue date of your policy.

DOCTOR	STREET ADDRESS	CITY, STATE, AND ZIP CODE
1.		
2.		

I affirm that the above information is correct to the best of my knowledge and belief.

Signature _____ Date _____

POLICYOWNER'S SIGNATURE	DATE

Kemper Home Service Companies

Policy No(s):_____

Name of person this form applies to:

_____

SUBMIT CLAM TO:

HOME SERVICE INSURANCE SERVICES
1350 TIMBERLAKE MANOR PARKWAY
SUITE 200
CHESTERFIELD, MO 63017

HEALTH INSURANCE CLAIM – INDIVIDUAL

PART B (ID-1) ATTENDING PHYSICIAN'S STATEMENT

TO THE PHYSICIAN: It will be a service to your patient and our policyowner if you will answer ALL questions completely.

Patient's Name	Date of Birth	Height	Weight

Street Address	City	State	Zip Code

1. Nature of sickness or injury. (Describe complications if any.) If pregnancy, date of LMP.			
2. When did symptoms first occur or accident happen?	Date		
3. When did patient first consult you for this condition?	Date	Time	☐ A.M. ☐ P.M.
4. Has patient ever had same or similar condition? (If "yes" state when and describe.)	☐ Yes ☐ No		
5. Describe any other diseases or infirmity affecting present condition.			
6. Give dates of treatment.	Office	Home	Hospital
7. Nature of surgical procedure, if any. (Describe fully.) Please show charge and date for this procedure and where performed.	Procedure		Charge $
	Date	CPT Code	☐ In-Patient ☐ Out-Patient
8. If patient hospitalized, give name and address of hospital. (Inpatient Only)	Hospital	City	State
	Date Admitted ☐ A.M. ☐ P.M.	Date Discharged ☐ A.M. ☐ P.M.	
9. Is patient still under your care for this condition? If discharged, give date.	☐ Yes ☐ No	Discharge Date	
10. How long was (or will) patient be continuously TOTALLY disabled?	From	To	
11. If patient is considered totally disabled, please describe how condition or injury will cause inability to perform one or more of the daily duties of patient's occupation or activities of daily living.			

Physician's Full Name (Please Print)	Degree	Taxpayer identification number as required by law.

Full Street Address	City, State, and Zip Code

Physician's Signature	Telephone	Dated