

Policyholder name: **UNITED BUSINESS ASSOCIATION** Policy No. \_\_\_\_\_

Name of Certificate Holder \_\_\_\_\_ I.D.# \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_  
\_\_\_\_\_ Cell phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Name of Claimant \_\_\_\_\_ Relationship: \_\_\_\_\_ D.O.B. \_\_\_\_\_

1. Date of injury or beginning of sickness \_\_\_\_\_ When was physician first consulted? \_\_\_\_\_

2. Nature of injury or sickness \_\_\_\_\_

3. If injury, describe how and where accident occurred \_\_\_\_\_

4. Have you suffered same or similar condition before? No Yes If yes, and you were previously treated, dates treated:

Name and address of physician(s) who treated you: \_\_\_\_\_

5. If hospitalized at that time, date confined to hospital: \_\_\_\_\_

Name and address of hospital: \_\_\_\_\_

6. Name and address of primary care physician: \_\_\_\_\_

7. Do you have other insurance that covers your condition (group, individual, automobile, medical or liability)? No Yes

8. If yes, who is the Holder of Policy Self Parent Spouse Name of Insurance Co. \_\_\_\_\_

If covered under Parent's/Spouse's Insurance or if privately insured, please include the following information:

Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_ Phone No. of Insurance Co. \_\_\_\_\_

Parent's/Spouse's Name (Holder of Policy) \_\_\_\_\_ I.D. No. \_\_\_\_\_

Employer's Name and Address \_\_\_\_\_

**NEW YORK FRAUD WARNING:** 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.

**AUTHORIZATION:** I hereby authorize Crum & Forster, United States Fire Insurance Company or its representative, to inspect or secure copies of case history records or any other data necessary to determine eligibility of benefits. I also authorize Crum & Forster, United States Fire Insurance Company or its representative to release and share claim information including that which may be used in the identification and prevention of potential fraudulent activity to any insurance organization, fraud information clearinghouses, designated service providers and business associates assisting in the processing of this claim. A photostatic copy or facsimile of this authorization shall be deemed as effective and valid as the original. This authorization is valid for twelve (12) months from date of signature. **I HAVE REVIEWED AND ACKNOWLEDGE THE ATTACHED FRAUD WARNING.**

SIGNATURE OF INSURED \_\_\_\_\_ DATE \_\_\_\_\_

**PLEASE SEE FOLLOWING PAGE FOR CLAIM FILING INSTRUCTIONS**

## HOW TO FILE A CLAIM

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

- Complete this claim form, in full.
- Attach a fully itemized bill. These can be obtained directly from the patient's healthcare provider(s) by requesting a **UB04 hospital bill or HCFA or CMS 1500 non-hospital bill**. Balance due or non-itemized bills will not be accepted.
- Failure to complete all sections may result in a delay in processing this claim.

### SUBMIT TO:

**Claims and Correspondence Mailing Address: Co-ordinated Benefits Plans  
P.O. Box 23802  
Tampa, FL 33623**

Claims may be scanned & emailed to CBP at: [team2@cbpinsure.com](mailto:team2@cbpinsure.com)

Customer Care Phone Number: 877-442-7029 (Customer Care hours from 8:00 am – 6:00 pm Eastern)

On-line claim status address: CBPConnect.com (<https://cbpconnect.com>)

**Keep copies of all claims forms, bills and correspondence for your own records.  
Written Proof of Loss must be furnished within 90 days after the date of such loss.**

**CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:**

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.

**ALASKA:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**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.

**FLORIDA WARNING :**Any person who knowingly and with intent to injure, defraud, or deceive any insurer 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.

**KANSAS:** 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

**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

**MARYLAND:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NEW HAMPSHIRE:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

**NEW MEXICO and PENNSYLVANIA:** 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 subjects such person to criminal and civil penalties.

**OHIO:** Any person who, with 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 is guilty of insurance fraud.

**OKLAHOMA:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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

**CLAIM FORM FRAUD STATEMENT** - continued

**TEXAS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**VIRGINIA:** 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 state law.