HOSPITAL INCOME BENEFIT (HIB) RIDER CLAIM FORM

DATE: _____

Cooperative Name: _____

Exact Address of Cooperative: _____

Coop's Bank Details: Account Name: _____

Account Number: _____ Bank: _____

Name of MEMBER: _____ Coop Membership Date: _____

Beneficiary/Contact Person: _____ Contact Number: _____

Rider: **HOSPITAL INCOME BENEFIT**
Coverage: From _____ To: _____

Details of Claim:

Reason for confinement: _____

Describe in detail the nature of your claim/symptoms of your illness: _____

_____

_____

_____

Requirements:

1. Claimant's Statement (Hospital Income Benefit) form
2. Attending Physician's Statement
3. Photocopy of valid photo-bearing identification document of Claimant/s with 3 specimen signatures
4. Billing/Statement of Account
5. Medical Abstract / Admitting History

Declaration and Authorization

I declare that all answers given by me in this form are true and complete, and to the best of my knowledge and belief all are based on official records.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the industry association database, consumer reporting agency, entity or employer, having information available as to diagnosis, treatment, results and prognosis, with respect to my physical or mental examination or condition, to give to NATCCO MBAI any and all information, or any other information or record it may need.

This form pertains to all records containing medical or non-medical data including, but not limited to, mental and dental care, drug or alcohol use, prescribed drugs, information about communicable diseases, and any employment and insurance coverage information.

I also authorize NATCCO MBAI to request, secure and to obtain any or all information's, records or documents which are available from any medical practitioner, government/private hospitals/clinics, medical offices/clinics or any investigative report from its duly authorized inspection agency which will provide any applicable information concerning the processing of this claim for insurance benefits on the life of the insured.

I agree that a photographic copy of this Authorization shall be valid as the original. This authorization discharges any such physician, medical practitioner, hospital, clinic, medical office or facility and all members of its staff from any liability or obligation by reason of the release of such information/document/record.

_____

Claimant's Signature over Printed Name

_____

Date Signed

TO BE FILLED OUT BY NATCCO MBAI CLAIMS UNIT:

Valid IDs: Type: _____ ID#: _____

Documents Presented: _____

Documents received and validated by: _____

Date: _____

Notes:

_____

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