Dear Valued Policyholder,

At Senior Health Insurance Company of Pennsylvania, we understand that filing a new long term care insurance claim can be confusing. To provide clarity in filing a new claim, this claim information package is designed to provide you with straightforward instructions on how to file a claim under your long term care policy.

Claim Filing Instructions:

1. The contents of this claim information package include:

    - Claim Forms - Claim forms must be completed for each new claim but the forms do not need to be submitted on an ongoing basis. There are four pages of claim forms:
        - **Page 1 and 2 – Policyholder Claim Form**: completed by the policyholder or legal representative
        - **Page 3 – Authorization For Use of Health-Related Information**: completed by the policyholder or legal representative
        - **Page 4 – Authorization For Disclosure of Health-Related Information**: (optional) completed by the policyholder or legal representative if you want to authorize anyone other than the policyholder to speak with us about your claim.
    - Direction to Pay Cover Letter and Form – this form should only be completed if you wish to assign claim payments directly to your provider. Please note that in order for us to pay the provider directly, we will only accept our Direction to Pay form.
    - Caregiver Weekly Timesheet – this form only needs to be completed for home health care claims and must be completed on a weekly basis to document the services provided each day
    - Nursing Facility Checklist – this is designed to help you stay organized while submitting a new nursing facility claim. This checklist does not need to be returned.
    - Home Health Care Checklist – this is designed to help you stay organized while submitting a new home health care claim. This checklist does not need to be returned.

2. Complete the first three pages of the Claim Form. Also complete page 4, the **Authorization For Disclosure of Health-Related Information,** if you want to authorize anyone other than the policyholder to speak with us about your claim. Please submit all of these forms to us together. PLEASE ALSO MAKE SURE THAT ITEMIZED INVOICES ARE SUBMITTED TO US.

3. Provide copies of supporting documents that are applicable to your situation (e.g., Power of Attorney documentation). Ensure that your long term care claim submission is complete by reviewing the enclosed checklist specific to the claim you are filing (Home Health Care or Nursing Facility). Submit your claim by mailing or faxing the claim information to us at the address or fax number listed on the bottom of each claim form.

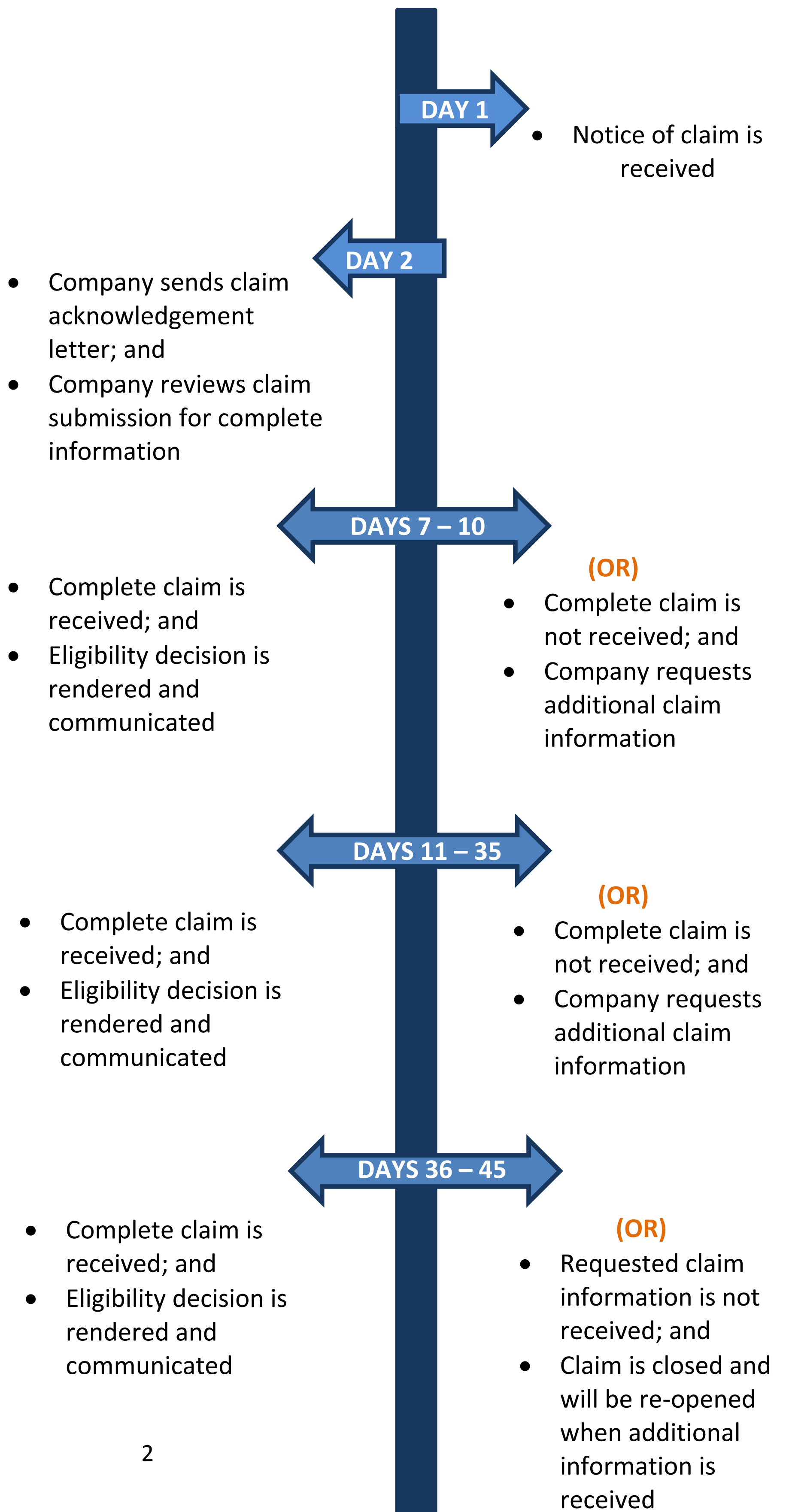
What to Expect from Us

When your claim is received, a letter will be sent to you within four to six business days acknowledging receipt of your claim request. Please note that documents mailed or faxed separately will result in multiple acknowledgement letters to you for each separate mailing.

Your claim submission will be reviewed within two to six days of receipt. If the claim information received is complete, a benefit eligibility decision will be made within ten business days from date the claim submission is received. If there are questions regarding your claim submission or if additional information is required, you and/or your provider will be contacted within the first ten business days as we attempt to gather the complete information. Please be sure to provide the telephone number and name of the person you would like us to contact in this situation on the Policyholder's Claim Form.

Multiple attempts will be made to gather all necessary information. Your claim may be closed if the requested information is not received. Your claim will be re-opened and reviewed when the additional information is received.

INITIAL CLAIM TIMELINE



Approved Claims

Following the eligibility decision, if both you and your provider meet the requirements of your policy, you will receive written notification from us. However, benefits will still not be provided until we receive itemized invoices from either the policyholder, caregiver or facility. The care manager handling your claim will also attempt to call you or your authorized designee. Please be sure to provide the telephone number and name of the person who should be notified following the benefit determination.

When submitting your claim, you must provide itemized invoices documenting monthly, daily or hourly rates charged for each service date. **No benefits will be provided until itemized invoices are received by us from either the policyholder, facility or the caregiver(s). We will not be obtaining invoices on your behalf.** For Home Health Care claims, you must also provide Caregiver Weekly Timesheets or daily progress notes documenting the services you received for each day of paid care. If you prefer benefit payments be made directly to your provider, you must complete the Direction to Pay form, which is included in this package. The standard timeframe for benefit payments is five to ten business days from the date the claim is approved (or the date we receive the itemized invoice.) You will receive an explanation of benefits letter for all claims paid.

Ineligible Claims

Following the eligibility review, if either you or your provider do not meet the requirements outlined in your policy, you will receive written notification. The care manager handling your claim will also attempt to call you or your authorized designee to explain the reason for the benefit determination and explain the process to appeal a claim determination.

Should you have any questions regarding your policy benefits, please contact our Customer Service team by calling 1-877-450-5824, Monday through Friday, from 8:00 AM to 6:00 PM (Eastern), or you may visit our website at www.SHIPLTC.com.

Thank you for allowing us the opportunity to serve your long term care insurance needs.

Claim Forms

Policyholder Claim Form
Authorization for Use of Health Related Information
Authorization for the Disclosure of Health Related Information

Please submit all of these forms together. Please be aware that the Authorization for the Disclosure of Health Related Information is only required if you would like us to be able to speak to someone other than you about your care. Otherwise, that form does not need to be returned. **No benefits will be provided until itemized invoices are received by us from either the policyholder or the caregiver(s). We will not be obtaining invoices on your behalf.**

Completed forms should be mailed or faxed to:

Senior Health Insurance Company of Pennsylvania
P.O. Box 64913
St. Paul, MN 55164
Fax: (952) 983-5256

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POLICYHOLDER CLAIM FORM

1. List ALL policy numbers under which you want to file a claim:

   Policy Number: ______________________________ Policy Number: ________________________________

   Policy Number: ______________________________ Policy Number: ________________________________

2. Policyholder's Name (Claimant): ______________________________ Social Security #: _______-_______-_________

   Date of Birth: ____/____/____ (MMDDYYYY) Gender: ☐MALE ☐FEMALE Phone Number: (______) _______ - _______

   Current Address: ____ City:________________ State: ______ Zip: ____________

   What type of residence is this? ☐Private Residence ☐Nursing Home

   ☐Assisted Living Facility ☐Other: ______________________

3. The address to which all policy correspondence, including claim payments, should be mailed:

   ☐ Same as above ☐ Address shown below:

   Address: ____ City: __________________ State: ________ Zip: ________

4. Cause or condition that caused you to require Long Term Care services: ☐Sickness ☐Accident

   ____

   ____

5. Date of the onset for this sickness or accident: ______/______ /______ (MMDDYYYY)

6. Is this claim related to an accident and someone else appears to be at fault? ☐YES ☐NO

7. The date you first sought treatment for this condition: ______/______ /______ (MMDDYYYY)

   Name of first treating physician: _____________________________________

   Address: ____ City: __________________ State: ______ Zip: _________

   Phone Number: (_______) _________ - ________ Fax Number: (_______) _______ - ________

8. Is the physician above your family or primary care physician? ☐YES ☐NO

   If NO, please provide your family or primary care physician information:

   Family/Primary Care Physician Name: ____

   Address: ____ City: __________________ State: ________ Zip: ________

   Family/Primary Care Physician Phone Number: (_____) ______ - ______ Fax Number: (_____) _______ - _______

9. Privacy Laws restrict the information we can release to anyone other than the policyholder.
   NOTE: IF YOU HAVE DESIGNATED A POWER OF ATTORNEY, PLEASE ATTACH THE DOCUMENTATION.

   Have you designated a POWER OF ATTORNEY? ☐YES ☐NO

   The primary person to whom you have given POWER OF ATTORNEY: ____

   Home Number: (______) _______- ________ Office: (______) _______- ________ Cell: (______) _______- _________

   IF YOU HAVE DESIGNATED SOMEONE TO ACT ON YOUR BEHALF IN FILING THIS CLAIM, PLEASE ALSO COMPLETE THE "AUTHORIZATION FOR DISCLOSURE OF HEALTH-RELATED INFORMATION" FORM.

   Have you designated someone to act on your behalf? ☐YES ☐NO
   Person designated to act on your behalf in filing this claim: ____

   Home Number: (______) _______- ________ Office: (______) _______- ________ Cell: (______) ______- _________

POLICYHOLDER CLAIM FORM

10. Agency/Facility/ Provider Name: ______________________________ Provider Tax ID Number: ______________________
    Address: ____________________________________ City: ________________ State: __________ Zip: ____________________
    Phone Number: (___) ______- ___________ Fax: (___) _____- ___________ Cell: (___) __________-______________
    NOTE: PLEASE ATTACH COPIES OF THE LICENSE OR CERTIFICATION, IF AVAILABLE.
11. Start of care date: ____/____/______(MMDDYYYY) End of care date: ______/______/______(MMDDYYYY)
12. Was any period of the patient's care covered by Medicare? ☐ YES ☐ NO
    If YES, please list the dates: ____
13. Was the care preceded by a hospital stay? ☐ YES ☐ NO
    If YES, please provide admission and discharge dates: ____
    Hospital Name: ____
    Address: ____ City: _________________ State: _____ Zip: ________
    Phone Number: (_______) ___________- ____________ Fax Number: (______) ___________- _____________
14. Since the date care started, have there been any breaks in care? ☐ YES ☐ NO
    If YES, please provide explanation and dates: ____
    ____
    ____
    ____

I certify that the information above is accurate and complete to the best of my knowledge.

Policyholder or Legal Representative Signature: ____ Date: ____________________

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

AK RESIDENTS: 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.

AZ RESIDENTS: 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.

AR, TX RESIDENTS: 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.

CA RESIDENTS: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

CO RESIDENTS: 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.

DE, ID RESIDENTS: Any person who knowingly and with intent to defraud or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

DC RESIDENTS: 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 insurance benefits if false information materially related to a claim was provided by the applicant.

FL RESIDENTS: 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.

IN RESIDENTS: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

KY RESIDENTS: 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.

LA RESIDENTS: 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.

MD, RI RESIDENTS: 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.

MN RESIDENTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NM, WV RESIDENTS: 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 civil fines and criminal penalties.

ME, TN, VA, WA RESIDENTS: 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.

NH RESIDENTS: 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.

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

NY RESIDENTS: 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 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.

OH RESIDENTS: 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.

OK RESIDENTS: WARNING: 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.

OR, PA RESIDENTS: 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.

PR RESIDENTS: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

AUTHORIZATION FOR USE OF HEALTH-RELATED INFORMATION
(This authorization complies with HIPAA Privacy Rules.)

Name of Policyholder:	Policy Number:
Address Line 1:	Address Line 2:
City, ST, Zip:	Date of Birth: ____/ _____/ _______

NOTE: If this form is completed by a Legal Representative then a valid Power of Attorney, Guardianship, Conservatorship or similar documentation must accompany this form.

Use of Health Related Information *to* Senior Health Insurance Company of Pennsylvania

I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically-related facility, pharmacy, pharmacy benefits manager, federal, state or local government agency, insurance or reinsuring company, third-party claims administrator, consumer reporting agency, employer, Medical Information Bureau (MIB) or any other organizations, institutions or persons with knowledge or records of me and my health, including but not limited to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to **Senior Health Insurance Company of Pennsylvania** ("the Company"), or its legal representative. I understand that information obtained by use of this authorization, including individually identifiable health information, may be used for the purpose of administering my insurance benefits and/or making eligibility, risk or claim determinations, and that this information may be transferred to any organization or person employed by or representing the Company to assist with this purpose. I understand that information disclosed under this authorization may include medical records and reports concerning my physical or mental health and any and all associated diagnoses, prognoses, care or treatments, diagnostic and laboratory tests, prescription drug information and history, and information regarding drug use, alcoholism, mental illness, sexually transmitted diseases, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company or their authorized administrator and may no longer be protected by the same rule that applied in the first instance. This authorization is valid while my claim is pending, while it remains active or in order for the Company to process my appeal or administer benefits. Except in the case of an appeal, this authorization shall expire on the date my claim ends or seven years from the date of my signature below, whichever is later. I understand that my authorized representative or I have the right to request and receive a copy of this authorization. A photocopy of this authorization shall be as valid as the original.

I understand that my authorization is voluntary and that I can refuse to sign this authorization. I do understand, however, that failure to sign this authorization may impair the Company's ability to evaluate my claim and may be a basis for denying a claim for benefits. I further understand that I have the right to revoke this authorization by notifying the Company in writing at **Senior Health Insurance Company of Pennsylvania***, Attn: Claim Review, PO Box 64913, St. Paul, MN 55641.* Such revocation may be the basis for denying benefits.

IMPORTANT: Policyholder (or Legal Representative) Signature: X________________________________

Date: ________________________________

Type of authority to act on behalf of the insured (please check box, if applicable):

☐ Legal Representative ☐ Power of Attorney ☐ Guardianship ☐ Conservatorship

AUTHORIZATION FOR DISCLOSURE OF HEALTH-RELATED INFORMATION

(This authorization complies with HIPAA Privacy Rules.)

Name of Policyholder:	**Policy Number:**
Address Line 1:	**Address Line 2:**
City, ST, Zip:	**Date of Birth:** ____/ _____/ _______

NOTE: If this form is being completed by a Legal Representative then a valid Power of Attorney, Guardianship, Conservatorship, or similar documentation must accompany this form.

Health Information to be Disclosed *by* Senior Health Insurance Company of Pennsylvania

I authorize the Company to disclose my Protected Health Information to the following

(Person/Organization Receiving Information): ____

____

The Relationship of this person/organization to me is: ______________________________________

This recipient may use the health information authorized on this form for the following purpose(s):

____

____

This authorization shall be effective as of the date of my signature below. I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by giving written notice to: **Senior Health Insurance Company of Pennsylvania**, *Attn: Claim Review, PO Box 64913, St. Paul, MN 55164.* I understand that the Company may not deny me benefits due to refusal to sign this authorization. I further understand that my signature on this form does not authorize any changes to my policy information or to my policy or change the way the Company communicates with me. I also understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. The undersigned is entitled to receive a copy of this form. A photocopy of this authorization shall be as valid as the original.

Policyholder (or Legal Representative)

Signature: X ___________________________________ Date: _______________________

Type of authority to act or sign on behalf of the policyholder (please check box, if applicable):

☐ Legal Representative ☐ Power of Attorney ☐ Guardianship ☐ Conservatorship

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA
P.O. Box 64913 • St. Paul, MN 55164
Telephone: 1-877-450-5824

Dear Policyholder:

If you choose to assign your long term care insurance benefits to a covered provider, you must submit additional information in writing to us. In order to assign benefits, please be advised that we will only accept the Direction to Pay form. The provider must agree to this Direction to Pay and be willing to bill your long term care insurance company directly for care/services provided to you. The Direction to Pay form is provided as a convenience to our policyholders and their care providers to assign benefits to the care provider, but not the rights under the policy.

In order to direct benefits to your care provider, we need the following:

- ☐ Complete the enclosed "Direction to Pay" form.
- ☐ Obtain the consent of the provider to accept assignment and bill us directly.
- ☐ Return the "Direction to Pay" form to us via mail or fax it to us at 952-983-5256.

In addition, the covered provider must send us a completed W-9 form (required by the IRS). The "Direction to Pay" will not be in effect until we receive the enclosed "Direction to Pay" form from you and the enclosed W-9 form from your covered provider. **Please return via fax: at** 952-983-5256 **or mail to:**

SHIP
P.O. Box 64913
St. Paul, MN 55164

Should you have any questions, please contact Customer Service at 877-450-5824, between the hours of 8:00 a.m. and 6:00 p.m. (Eastern Time) Monday through Friday.

Sincerely,

SHIP Customer Service

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA
P.O. Box 64913 • St. Paul, MN 55164
Telephone: 1-877-450-5824

Direction to Pay

Claimant Name: ___________________________ Policy Number: ___________________________

This Direction to Pay revokes any previous assignments authorized by ____________________________, the Claimant or the guardian of the Claimant (legal documentation of guardianship or other representative capacity, if appropriate, is attached), and hereby authorizes direct payment to ________________________, the service provider, for any Long-Term Care benefits otherwise payable to or on behalf of the Claimant for covered services at a rate not to exceed the Provider's regular charges. It is understood that this Direction to Pay does not transfer any rights under the policy of insurance. It is agreed that payment to the Provider, pursuant to this Direction to Pay, by the plan administrator shall discharge this long term care insurer of any and all obligation under the plan to the extent of such payments. It is understood by the undersigned that he/she is financially responsible for any charges not covered by this Direction to Pay.

____
Service Provider Representative Signature

____
Printed Name of Service Provider Representative

____
Date

____
Claimant/Legal Representative Signature

____
Printed Name of Claimant/Legal Representative

____
Date

☐ Financial Power of Attorney is attached if signed by a Legal Representative

Name of Service Provider: ____

Address of Service Provider:______________________________ City: ___________ State: _____Zip: ______

Provider's Federal Tax ID Number: _______________________

<u>A completed W-9 form verifying the provider's Federal Tax ID Number is required for benefit assignment.</u>

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

• The U.S. owner of a disregarded entity and not the entity,

• The U.S. grantor or other owner of a grantor trust and not the trust, and

• The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required federal tax documents on the “Name” line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the “Business name/disregarded entity name” line.

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the “Exempt payee” box in the line following the “Business name/disregarded entity name,” sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	**THEN the payment is exempt for . . .**
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt payees 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner’s SSN (or EIN, if the owner has one). Do not enter the disregarded entity’s EIN. If the LLC is classified as a corporation or partnership, enter the entity’s EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write “Applied For” in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering “Applied For” means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the “Name” line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity [4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

CAREGIVER WEEKLY TIMESHEET

Return Forms to:
SHIP
PO Box 64913
St. Paul, MN 55164-0913

Insured:

Policy Number:

CHARTING KEY
X = Not done today
I = Insured performed task Independently
S = Supervise/ Standby Assist within arm's reach
A =Hands-on Assistance required to complete task

CAREGIVER INSTRUCTIONS

1. Complete a new timesheet each week.
2. Indicate in EVERY box EACH day the level of assistance provided ON THAT DAY using the Charting Key to the right.
3. Enter the start & end times, number of hours worked, and total pay EVERY day along with a weekly total pay at the end.
4. Write a daily note describing the insured's care needs, problems, appointments, important events, or change in condition.
5. Print your name, relationship to insured, sign, and date the completed form

Activity Date	Reimbursement Rate $____/ Hour or Day	Feed	Bath	Dress	Toilet / Continent	Walk / WC	Transfer	Meds	Meal Prep	Clean & Laundry	Shop & Transport
Monday	Time In										
	Time Out	Daily Note									
__/___/___	Total # Hrs										
	Mon Pay $										
Tuesday	Time In										
	Time Out	Daily Note									
__/___/___	Total # Hrs										
	Tues Pay $										
Wednesday	Time In										
	Time Out	Daily Note									
__/___/___	Total # Hrs										
	Wed Pay $										
Thursday	Time In										
	Time Out	Daily Note									
__/___/___	Total # Hrs										
	Thurs Pay $										
Friday	Time In										
	Time Out	Daily Note									
__/___/___	Total # Hrs										
	Fri Pay $										
Saturday	Time In										
	Time Out	Daily Note									
__/___/___	Total # Hrs										
	Sat Pay $										
Sunday	Time In										
	Time Out	Daily Note									
__/___/___	Total # Hrs										
	Sun Pay $										

***TOTAL WEEKLY PAY* $**_____________ Caregiver relationship to Insured: _______________ Caregiver SSN#:______________

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I KNOW IT IS A CRIME TO COMPLETE THIS FORM WITH INFORMATION I KNOW IS FALSE OR TO OMIT ANY FACTS I KNOW ARE IMPORTANT

Print Caregiver Name ______________________________ Signature __________________________________ Date_________________

****

INSURED / REPRESENTATIVE INSTRUCTIONS:

1. Verify the accuracy of the services provided and reimbursement information above.
2. Complete the form with your name, date, and signature.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I KNOW IT IS A CRIME TO COMPLETE THIS FORM WITH INFORMATION I KNOW IS FALSE OR TO OMIT ANY FACTS I KNOW ARE IMPORTANT

Print Insured / Legal Representative Name ______________________ Signature ________________________ Date _______________

If you have any questions, please call 877-450-5824

☑ NURSING FACILITY / ASSISTED LIVING FACILITY INITIAL CLAIM CHECKLIST

CHECK OFF EACH ITEM AS YOU COMPLETE IT TO HELP YOU KEEP TRACK OF YOUR CLAIM SUBMISSION
(THIS CHECKLIST IS FOR YOUR CONVENIENCE ONLY AND DOES NOT NEED TO BE RETURNED TO US)

TO DO: POLICYHOLDER

- ☐ CLAIM FORM PAGES 1 AND 2: COMPLETE ALL OF THE QUESTIONS 1-14
- ☐ CLAIM FORM PAGE 3: "AUTHORIZATION FOR USE OF HEALTH-RELATED INFORMATION"
- ☐ CLAIM FORM PAGE 4: COMPLETE "AUTHORIZATION FOR DISCLOSURE OF HEALTH-RELATED INFORMATION," IF YOU WOULD LIKE US TO BE ABLE TO SPEAK TO SOMEONE OTHER THAN YOU ABOUT YOUR CARE. OTHERWISE, THIS FORM DOES NOT NEED TO BE RETURNED
- ☐ DIRECTION TO PAY FORM (REQUIRED IF DIRECTING BENEFIT PAYMENTS TO PROVIDER)

TO DO: OTHER FORMS

- ☐ NURSING HOME / ASSISTED LIVING FACILITY LICENSE (IF AVAILABLE)
- ☐ MINIMUM DATA SET (MDS) OR NURSING ASSESSMENT
- ☐ PLAN OF CARE OR SERVICE PLAN (IF AVAILABLE)
- ☐ ITEMIZED INVOICE MUST BE SUBMITTED BY THE POLICYHOLDER, CAREGIVER OR FACILITY FOR ANY BENEFITS TO BE PROVIDED BY US
- ☐ MEDICATION LIST AND PHYSICIAN'S MEDICATION ORDER (IF APPLICABLE)

IMPORTANT: PLEASE MAKE PHOTOCOPIES OF ALL CLAIMS MATERIALS AND RETAIN FOR YOUR RECORDS!

MY NOTES:

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☐ MAILED ON _____/_____/_______ TO:

SHIP
P.O. BOX 64913
ST. PAUL, MN 55164

☐ FAXED ON _____/_____/_______ TO:

(952) 983-5256

☑ HOME HEALTH CARE INITIAL CLAIM CHECKLIST

CHECK OFF EACH ITEM AS YOU COMPLETE IT TO HELP YOU KEEP TRACK OF YOUR CLAIM SUBMISSION
(THIS CHECKLIST IS FOR YOUR CONVENIENCE ONLY AND DOES NOT NEED TO BE RETURNED TO US)

TO DO: POLICYHOLDER

☐ CLAIM FORM PAGES 1 AND 2: COMPLETE ALL OF THE QUESTIONS 1-14

☐ CLAIM FORM PAGE 3: COMPLETE "AUTHORIZATION FOR USE OF HEALTH-RELATED INFORMATION"

☐ CLAIM FORM PAGE 4: COMPLETE "AUTHORIZATION FOR DISCLOSURE OF HEALTH-RELATED INFORMATION," IF YOU WOULD LIKE US TO BE ABLE TO SPEAK TO SOMEONE OTHER THAN YOU ABOUT YOUR CARE. OTHERWISE, THIS FORM DOES NOT NEED TO BE RETURNED

☐ DIRECTION TO PAY FORM (REQUIRED IF DIRECTING BENEFIT PAYMENTS TO PROVIDER)

TO DO: OTHER FORMS

☐ CAREGIVER CERTIFICATION / NURSING LICENSE (IF AVAILABLE)

☐ HOME HEALTH AGENCY LICENSE (IF AVAILABLE)

☐ PLAN OF CARE OR NURSING ASSESSMENT (IF AVAILABLE)

☐ ITEMIZED INVOICE MUST BE SUBMITTED BY THE POLICYHOLDER, CAREGIVER OR FACILITY FOR ANY BENEFITS TO BE PROVIDED BY US

☐ DAILY VISIT NOTES

IMPORTANT: PLEASE MAKE PHOTOCOPIES OF ALL CLAIMS MATERIALS AND RETAIN FOR YOUR RECORDS!

MY NOTES:

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____

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☐ MAILED ON ____/____/______ TO:

SHIP
P.O. BOX 64913
ST. PAUL, MN 55164

☐ FAXED ON ____/____/______ TO:

(952) 983-5256

By reviewing this **Claim Information Package** you have taken the first step in initiating a new claim submission. This package comes with all the information you will need to help you get the claim filing process started. Below are more **frequently asked questions** about filing a new claim under your Long Term Care insurance policy.

Q. What claim forms must be completed for every claim?
A. The required forms are included within this Claim Information Package. Complete the first three pages of the Claim Form. Also complete page 4, the **Authorization For Disclosure of Health-Related Information,** if you want to authorize anyone other than the policyholder to speak with us about your claim. Please submit all of these forms to us together. PLEASE ALSO MAKE SURE THAT ITEMIZED INVOICES ARE SUBMITTED TO US. If you are filing a Home Health Care claim, the enclosed Caregiver Weekly Timesheets may be used if your provider does not supply them.

Q. Is there any information, other than claim forms, needed to make a claim determination?
A. Once we receive completed claim forms, it may be necessary for us to obtain additional documentation to make an accurate determination of eligibility for benefits. The additional documentation may include, but is not limited to, physician and hospital records, the provider's license (if applicable) and care provider notes. In all cases itemized bills must be submitted to us for benefits to be provided. It is very important to make copies of all correspondence being sent in to file the claim so that you have a record of what you have submitted. Please refer to the appropriate enclosed initial claim checklist for detailed guidance on completing the claim forms, as well as, the additional documentation we may need.

Q. Who completes the claim form?
A. We request that the policyholder or legal representative fully complete the Policyholder Claim Form and the "Authorization For Use of Health-Related Information." The policyholder or legal representative should also complete the "Authorization for Disclosure of Health-Related Information," if you want to authorize us to speak to anyone other than the policyholder about this claim. Be sure to return these documents to us at the same time.

Q. What is a Direction to Pay form?
A. A Direction to Pay form allows us to pay your care provider directly. This is not a permanent assignment of policy benefits; you have the right to change your mind at any time in the future. This form is only required if you would like us to send any payable benefits directly to your provider. In order to assign benefits, please be advised that we will only accept the Direction to Pay form. In addition, your provider must send us a completed W-9 form (required by the IRS).

Q. How can I find an approved provider in my area?
A. If you need assistance locating an eligible provider, please contact our Customer Service team. They will mail a list of qualified providers within 10 business days from the date of your request.

Q. Where can I get more claim forms?
A. Claim forms can be obtained by contacting our Customer Service team. You can also download claim forms from our website, www.SHIPLTC.com.

Q. Who can answer questions or concerns about the status of a claim or the claim process?
A. Our Customer Service Representatives will be happy to clarify policy benefits and explain the claim process, although some privacy regulations may apply. If you have questions regarding a claim, please contact us at the telephone number listed on the bottom of each claim form.

Q. Where should I send the completed claim forms?
A. Our mailing address and fax number are located on the bottom of each claim form and on the initial claim checklist.