Cash Indemnity Long-Term Care Claim Form

1. Personal Information

Name of Insured

Policy Number

Date of Birth

Contact Number

Address

2. Claim Information

Date of Injury/Illness

Description of Condition

Date Care Commenced

Name and Address of Care Facility or Provider

3. Activities of Daily Living (ADLs)

Please indicate which ADLs require assistance:

☐ Bathing

☐ Dressing

☐ Eating

☐

Toileting

Transferring

Continence
Details of Assistance Needed

4. Attending Physician Information

Physician Name

Contact Number

Address

5. Signature

Signature of Insured/Authorized Representative

Date