

Markel Insurance Company

MCA Administrators, Inc.
 P. O. Box 6540
 Harrisburg, Pa 17112
 800-427-9308/717-652-8040

PROOF OF LOSS

| | |
|-----------------------|--------------|
| NAME OF GROUP: | Special Risk |
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|-----------------------|--|
| POLICY NUMBER: | |
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SPECIAL RISK ACCIDENT AND SICKNESS CLAIM FORM**INSTRUCTIONS:**

- 1.) You must have SECTION A fully completed by a designated official of the Policyholder.
- 2.) SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
- 3.) If claimant is treated in the hospital, please attach an itemized hospital bill.
- 4.) If claimant is treated by a doctor, have the doctor complete the Physician's Statement or attach an itemized bill.
- 5.) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service.
- 6.) Please mail completed form and bills to above address.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A

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| LOCATION OF GROUP POLICYHOLDER |
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|----------------------|------------------------------------|---------------|--------------------|
| CLAIMANT'S FULL NAME | SOCIAL SECURITY NO. (IF AVAILABLE) | DATE OF BIRTH | NAME OF SUPERVISOR |
|----------------------|------------------------------------|---------------|--------------------|

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|------------------------------|--|
| DATE ELIGIBLE COVERAGE BEGAN | DATE ELIGIBLE COVERAGE ENDED (IF APPLICABLE) |
|------------------------------|--|

GIVE FULL DETAILS OF INJURY OR ILLNESS (STATE NATURE OF INJURY/ILLNESS - INCLUDING PART OF BODY INJURED, DATE AND TIME)

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|------------------|---------------------|--|--|
| NAME OF ACTIVITY | DID ACCIDENT OCCUR: | | |
|------------------|---------------------|--|--|

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|---|------------------------------|-----------------------------|
| A. WHILE PERFORMING OCCUPATIONAL ON-DUTY ONLY ACTIVITY? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
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| B. WHILE COMMUTING TO/FROM WORK? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
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| DATE LAST WORKED | DATE RETURNED TO WORK | WEEKLY EARNINGS |
|------------------|-----------------------|-----------------|

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| POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE) | TITLE | DAYTIME TELEPHONE NUMBER () |
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| SIGNATURE OF POLICYHOLDER REPRESENTATIVE | DATE |
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SECTION B

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| NAME OF CLAIMANT | DAYTIME TELEPHONE NO. () |
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|---------------------|
| ADDRESS OF CLAIMANT |
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OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF INSURED, NAME AND ADDRESS OF INSURANCE COMPANY, NAME OF EMPLOYER AND POLICY NUMBER.)

YES _____ NO _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me and any other non-medical information of me to give to MARKEL INSURANCE COMPANY or its legal representative, and any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by MARKEL INSURANCE COMPANY to determine eligibility for insurance, and eligibility for benefits under any existing policy. Any information obtained will not be released by MARKEL INSURANCE COMPANY to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal service in connection with my application, claim, or as may be otherwise lawfully required of or as I may further authorize. I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of the Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for two and one-half years from the date shown below.

Affidavit: I CERTIFY that the information given by me in support of this claim is true and correct.

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| SIGNATURE OF CLAIMANT | DATE |
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Section C

HEALTH INSURANCE CLAIM FORM

CLAIMANT INFORMATION

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| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS/CHAMPVA GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (ID) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) | 1a. INSURED'S I.D. NUMBER |
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| 2. PATIENT'S NAME (First Name, Middle Initial, Last Name) | 3. PATIENT'S DATE OF BIRTH MM / DD / YY | SEX M <input type="checkbox"/> F <input type="checkbox"/> | 4. INSURED'S NAME (First Name, Middle Initial, Last Name) |
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| 5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/> (SPECIFY) | 7. INSURED'S ADDRESS (No., Street) |
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| | | | | |
|----------|---------------|---|----------|---------------|
| CITY | STATE | 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> | CITY | STATE |
| ZIP CODE | TELEPHONE NO. | Employed <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> | ZIP CODE | TELEPHONE NO. |

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| 9. OTHER INSURED'S NAME | 10. IS PATIENT'S CONDITION RELATED TO: | 11. INSURED'S POLICY GROUP OR FECA NUMBER |
| A. OTHER INSURED'S POLICY OR GROUP NUMBER | A. PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> | 3. PATIENT'S DATE OF BIRTH MM / DD / YY |
| B. OTHER INSURED'S DATE OF BIRTH MM / DD / YY | B. AN AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> | SEX M <input type="checkbox"/> F <input type="checkbox"/> |
| C. EMPLOYER'S NAME OR SCHOOL NAME | C. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> | B. EMPLOYER'S NAME OR SCHOOL NAME |
| D. INSURANCE PLAN NAME OR PROGRAM NAME | D. RESERVED FOR LOCAL USE | C. INSURANCE PLAN NAME OR PROGRAM NAME |
| 12. PATIENT'S OR AUTHORIZED PERSONS' SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to undersigned physician or supplier for service described below. |

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| Signature _____ Date _____ | Signature _____ Date _____ |
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| 14. DATE OF CURRENT: MM / DD / YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE: MM / DD / YY |
| 16. Dates Patient Unable To Work in Current Occupation MM / DD / YY FROM: / / TO: / / | | 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE |

| | | |
|---|---|----------------------------|
| 17a. I.D. NUMBER OF REFERRING PHYSICIAN | 18. Hospitalization Dates Related to Current Services MM / DD / YY FROM: / / TO: / / | 19. RESERVED FOR LOCAL USE |
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| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) | 20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 1 _____ 3 _____ | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. |
| 2 _____ 4 _____ | 23. PRIOR AUTHORIZATION NUMBER |

| 24. A | B | C | D | E | F | G | H | I | J | K |
|--|------------------|-----------------|--|----------------|------------|---------------|-------------------|-----|-----|------------------------|
| DATE(S) OF SERVICE FROM MM/DD/YY TO MM/DD/YY | Place of Service | Type of Service | PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | DIAGNOSIS CODE | \$ CHARGES | DAYS OR UNITS | DPSDT Family Plan | EMG | COB | RESERVED FOR LOCAL USE |
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| 25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | 28. TOTAL CHARGE \$ | 29. AMOUNT PAID \$ | 30. BALANCE DUE \$ |
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| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements apply to this bill and are made a part thereof.) SIGNED _____ DATE _____ | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office). | 33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE # PIN# _____ GRP# _____ |
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| PLACE OF SERVICE CODES 1-(H) - INPATIENT HOSPITAL 2-(OH) - OUTPATIENT HOSPITAL 3-(O) - DOCTOR'S OFFICE | 4-(H)-PATIENT'S HOME 5- -DAYCARE FACILITY (PSY) 6- -NIGHT CARE FACILITY(PSY) | 7-(NH) NURSING HOME 8-(SNF)-SKILLED NURSING FACILITY 9- -AMBULANCE | O-(OL)-OTHER LOCATIONS A-(IL)-INDEPENDENT LABORATORY B- -OTHER |
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FRAUD STATEMENTS

GENERAL: 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.

ALASKA: Any 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.

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.

ARKANSAS: 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.

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.

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

DISTRICT OF COLUMBIA 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.

FLORIDA: 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.

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

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.

LOUISIANA: 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.

MAINE: 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.

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

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

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: 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.

NEW YORK: 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.

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: 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.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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 act, which is a crime and subjects such person to criminal and civil penalties.

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.

TEXAS: 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.

VIRGINIA: 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.

WEST VIRGINIA: 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.