UNITED SECURITY INSURANCE COMPANY®
PO BOX 388199 • CHICAGO, IL 60638
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SECURITY ACCESS (FIXED INDEMNITY) CLAIM FORM

INSTRUCTIONS

Please type or print. The form must be completed in full and signed. Indicate "N/A" if item does not apply. **Return completed form along with an itemized provider statement (bill).** The statement must be prepared by the provider and include:

1. Patient name and date of service
2. A list of service(s) performed (CPT codes preferred) and the charge for each service
3. The diagnosis (ICD9 codes preferred)
4. The provider name, Federal Tax Ientification Number (FEIN or TIN), and contact information.

**** You must notify us of the claim within 60 calendar days after the date the covered event occurs or as soon as reasonably possible.***

SECTION 1 - POLICYHOLDER INFORMATION

Name (Last, First, Middle Initial)			Gender ☐ Male ☐ Female
Social Security Number	Date of Birth	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	
Street Address	City	State	ZIP Code+4
Policy Number			

SECTION 2 - PATIENT'S INFORMATION

Name (Last, First, Middle Initial)	Date of Birth	Social Security Number
Relationship to Policyholder ☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other _____		Date of Accident

Did this accident/illness occur at work?

Date of service on bills submitted: Earliest Date _____ Last Date _____

Report of Services: (attach itemized bill)

Date of Service	Description of surgical or medical services received

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician and/or Hospital providing services for which benefits are payable. This assignments will be honored only when the claim form from the provider of services does not contain any assignment of benefits or an indication that is on file.

_____ _____

Signature of Patient *(if minor, parent/guardian must sign)* Date