



Individual Long Term Care Claim Form Claimant's Statement

You must complete this form in full.
Please print or type all information except where signature is required.
Please return the completed form to the insured or authorized representative or
to CNA Insurance Companies, P.O.Box 64912 St. Paul, MN 55164-0912

Name of Insured		Date of Birth	Social Security Number	
Street Address		City	State	Zip
Phone Number ()		Policy Number(s)		
Name of closest relative/Power of Attorney (if applicable, please enclose a copy of the legal documents)			Relationship	
Street Address		City	State	Zip
Phone Number: Home		()		
		Work ()		

1. What type of benefits are you filing for?

- Nursing Home / Facility Home Health Care Other

Please provide the reason or condition for which you require care: _____

How long do you anticipate the need for care? _____

2. Were you in the hospital within 30 days prior to receiving Facility or Home Health Care? Yes No

If yes, please give the dates of hospitalization and the name of the hospital where you were a patient.

Date Admitted _____ Date Discharged _____

Hospital Name _____ Hospital Phone Number _____

()

Address _____

3. Please provide the name and address of your attending / primary physician (if you have more than one, please list the physicians information on the reverse side of this form):

Name _____ Phone Number _____

()

Address _____

4. Is Medicare or Medicaid providing benefits for any services for which you are filing this claim? Yes No

Please list all other insurance coverage, including Medicare or Medicare HMO.

Insurance Co. Name/Phone #: _____

Insurance Co. Name/Phone #: _____

I have read and understand the penalties imposed by various states for misrepresentation of information.

Signature of Claimant or Authorized Representative _____