



**U.S. LETTER CARRIERS  
MUTUAL BENEFIT ASSOCIATION  
100 INDIANA AVENUE, N.W.  
SUITE 510  
WASHINGTON, DC 20001  
(202) 638-4318**

**HOSPITAL INDEMNITY  
HOSPITAL CONFINEMENT  
HOSPITAL PLUS  
INSURANCE CLAIM FORM**

**1. Name of Member** \_\_\_\_\_ **Policy No:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **SS # :** \_\_\_\_\_  
**City, State & Zip Code:** \_\_\_\_\_ **NALC Branch #:** \_\_\_\_\_  
 \_\_\_\_\_ **Telephone #:** \_\_\_\_\_

**2. Patient Information**  
**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Relationship to Member:** \_\_\_\_\_

**3. Hospital Information (You Must Attach Copy Of Bill)**  
**Name of Hospital:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State & Zip Code:** \_\_\_\_\_  
**Date Admitted:** \_\_\_\_\_ **Date Discharged:** \_\_\_\_\_

**4. Physician or Surgeon Information (Doctor Ordering Hospitalization)**  
**Name:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State & Zip Code:** \_\_\_\_\_

**5. Diagnosis (Nature of Illness or Injury)** \_\_\_\_\_  
 \_\_\_\_\_

**6. Is the Physician listed in number 4 the only doctor you have seen for this condition?**  
 \_\_\_\_\_ (YES or NO)

If the answer to the above question is NO please list the names, addresses and Telephone numbers of all the doctors you have seen for treatment of this condition During the last 12 months.

**Doctor's Name:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State & Zip Code:** \_\_\_\_\_

**Doctor's Name:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State & Zip Code:** \_\_\_\_\_

I certify that the information furnished by me in support of this claim is true and correct to the best of my knowledge and belief and further that this hospital confinement is not due to any pre-existing condition as defined in my policy and as listed below.

\_\_\_\_\_  
 (Member's Signature) (Date)

I authorize physicians and medical institutions to furnish the U.S. Letter Carriers Mutual Benefit Association with any information regarding medical history, physical condition and diagnosis with respect to this claim and the determination of benefits under this policy. A copy of this authorization is as valid as the original.

\_\_\_\_\_  
 Patient's Signature (Member if Patient a Minor) (Date)

---

**PRE-EXISTING CONDITIONS.** No payment will be made under the Hospital confinement or Hospital Plus Insurance plan for pre-existing conditions (those conditions for which a Covered Person has received medical advice or treatment during the 12 months before coverage became effective) until the Covered Person has gone without further advice or treatment for 12 consecutive months or, if treatment has continued, until one year from the date when the insurance on the Covered Person became effective.

**“HOSPITAL”** means only a legally operated institution other than a convalescent, nursing or rest home; sanitarium or clinic; have accommodations for resident bed patient, established facilities for diagnosis or surgery (or having a bona fide arrangement with another “hospital” for the performance of surgery) and with 24 hour registered nursing service; but shall not include any special ward, floor, or institution operated primarily for the care and cure of mental conditions, intoxication, or alcoholism, drug addiction, or for the care of the aged.

**RECURRENT HOSPITAL CONFINEMENT.** Successive periods of hospital confinement due to the same or related causes for which Benefits are payable, not separated by six months or more, shall be deemed the result of the same sickness or injury and covered only if the policy is then in force. Successive periods of hospital confinement due to the same or related causes separated by six months or more shall be deemed the result of a new sickness or injury and covered only if the policy is then in force.

**“PHYSICIAN”** means physician or surgeon, other than the insured or a relative of the insured, who is licensed to practice medicine or surgery in the location where treatment is given.

**EXCEPTIONS.** The insurance provided by this policy does not pay benefits for hospitalization caused by: intentional self-inflicted injuries; acts of war or conditions sustained while in military service; full-time active duty with the armed forces of one or more countries. This does not apply to a period of two months or less of active duty for training purposes only. Upon written notice we will refund the portion of any premium paid for any period of active duty for training purposes of more than two months.

You are not covered for stays in: a convalescent, nursing, rest home or home for the aged; sanitarium or clinic; mental, alcoholic or narcotic institution; or in any facility not defined as a hospital in your policy.

**Claim will be delayed if all 6 questions are not fully completed and proper signatures are not affixed.**