HOSPITAL CONFINEMENT INDEMNITY
SUPPLEMENTAL CLAIM QUESTIONNAIRE

Claimant's Name: _____

Address: _____

_____

Policy #: MDX N11063457 Social Security #: _____ Date of Birth: _____

Please answer the following questions in as much detail as possible.

Name of Provider/Physician: _____
Address: _____

_____

Date of Service: _____

Please describe symptoms for which you were seeking treatment: _____

_____

_____

_____

_____

Have you been treated for the same or for a similar condition within the last 90 days? ☐ Yes ☐ No
If yes, please provide dates of treatment? _____

Was your visit to the doctor related to an annual wellness/preventive examination? ☐ Yes ☐ No

What was your doctor's diagnosis, as explained to you during your consultation? _____

_____

_____

What course of treatment did the doctor prescribe for you? _____

_____

_____

NOTE TO ALL PARTIES COMPLETING THIS FORM: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

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

_____ _____
Claimant's Signature (parent or legal guardian, if claimant is a minor child) Date

Mail claim to: Special Insurance Services, Inc.
P.O. Box 250349
Plano, TX 75025