Standard Life And Casualty Insurance Company
ATTN: Claims Department
PO Box 510690
Salt Lake City, UT 84151-0690
Fax: (801) 538-0392

HHC – EXTRA BENEFITS RIDER CLAIM FORM

Policyholder Information

Full Legal Name of Policyholder: _____

Policy Number: ___|___|___|___|___|___|___|___|___|___

Date of Birth: _____/_____/_____ **Phone No:** _____ - _____ - _____

Legal Residence Address: _____
Street *City* *State* *Zip*

☐ Annual Physical Examination Benefit Claim

Please provide with this form a copy of the following:

- Detailed proof of the physical exam (EOB, services rendered form, etc.)
- Sales receipt

☐ Home Medical Equipment Benefit Claim

Home Medical Equipment Category:

- □ Mobility Assistance
- □ Transfer Aids
- □ Bathroom Safety
- □ Home Accommodations
- □ Personal Medical Equipment

Medical Equipment – Detailed Description:

Please provide with this form a copy of the following:

- Sales receipt

☐ Accidental Death & Dismemberment Claim

Accident Information

Place of Accident: _____

Date of Accident: _____/_____/_____ **Time of Accident:** _____

Description of Accident and Nature of Injuries:

Treating Physician Information

Physician Name: _____

Physician's Tax ID Number: _____ **Phone No:** _____ - _____ - _____

Physician Address: _____
Street *City* *State* *Zip*

Policyholder Signature	Date Signed

Important Information

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review. Failure to complete all sections may result in a delay in processing this claim.

For information or to check claim status, call 1-800-327-0695.