

Trawick International

**HOW TO FILE YOUR
DISMEMBERMENT AND
LOSS OF USE CLAIM:**

1. **COMPLETE:** Claimant Section on the front of this form.
2. **READ & SIGN:** the Authorization and Legal notice section on the back of this form.
3. **HAVE YOUR DOCTOR:** complete the Physician's Statement on the back of this form.
4. **ANSWER ALL QUESTIONS:** missing information will cause a delay in your claim.
5. **FORWARD:** this form to your Administrator whose address is shown at the top of this form.
6. **CALL IF YOU HAVE ANY QUESTIONS:**
888-352-316
(Direct Dial 727-725-7522)

Attention: Co-ordinated Benefit Plans, LLC
On Behalf of Nationwide Mutual Insurance Company and Affiliated Companies
P.O. Box 26222, Tampa, FL 33623;
Or E-mail your information to: NWTravClaims@cbpinsure.com

Claimant Section:

School's Name: _____

Insured's Name: _____

Social Security #: _____ Date of Birth: _____

Relationship to Insured: Self Child
 Spouse Other _____

Policy #: _____

Phone Number: (____) _____

Address: _____

Check if this is a new address

Date of Accident: _____

Date of Dismemberment/Loss of Use: _____

Describe how the Accident occurred (provide accident report or supporting documents): _____

Hospital Confined: Yes No
If Yes, Dates: ____ \ ____ \ ____ to ____ \ ____ \ ____

Name and Address of Hospital: _____

For completion by Administrator:

Name of Insured: _____ Policy #: _____

Date of Birth: _____

Effective Date of Insurance: _____ Premium Paid to Date: _____

Date of Accident: _____

THIS STATEMENT HAS BEEN REVIEWED AND TO THE BEST OF OUR KNOWLEDGE AND BELIEF IS COMPLETE AND ACCURATE

Name of Administrator: _____ Phone Number: (____) _____

Address: _____

Signature: _____ Title: _____ Date: _____

Authorization & Legal Notifications

(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a 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.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(Louisiana) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

AUTHORIZATION: In order to determine eligibility for claim benefits, claim payment amounts, and identification and prevention of potential fraudulent activity:

1. I authorize any physician; hospital or other medical or medically related facility or provider; insurance company; insurance support organization or fraud information clearinghouse to release to: the insurance company(ies) underwriting the policy, its representatives or business associates assisting in the processing of the claim, any information regarding the medical history, symptoms, treatment, examination results or diagnosis or such other information needed to determine claim benefits for the deceased named below; and

2. I authorize the insurance company(ies) underwriting the policy, its representatives or business associates assisting in the processing of the claim, to disclose the claims information submitted to the insurance company(ies), its representatives or business associates assisting in the processing of the claim, to any insurance support organization or fraud information clearinghouse utilized by the insurance company(ies), or its representatives or business associates. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for a period not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization and that I may revoke this authorization at any time for information not then obtained upon providing written notice of such revocation of the authorization to the insurance company(ies) underwriting the policy, its representatives or business associates assisting in the processing of the claim.

 **Signature of claimant:** _____ **Date:** _____

ATTENDING PHYSICIAN'S STATEMENT
(this form is to be completed without expense to the Company)

Name of Patient _____ Date of Birth _____

Address _____
(No. & Street) (City) (State) (Zipcode)

1. NATURE OF LOSS (Describe Complications if any) _____

2. WAS THE LOSS THE RESULT OF AN ACCIDENT? Yes No

IF YES, GIVE DATE AND NATURE OF ACCIDENT _____

3. DID THE ACCIDENTAL INJURY RESULT IN THE SEVERENCE, OR TOTAL AND PERMANENT LOSS OF USE OF THE PATIENT'S HAND, ARM, THUMB/INDEX FINGER, LEG, TOE, EYE, EAR, SPEECH OR HEARING? Yes No

A. IF SEVERENCE, GIVE EXACT LOCATION AND MODE OF SEVERENCE _____

B. IF LOSS OF USE, DESCRIBE LOSS INCLUDING CAUSE _____

C. DO YOU BELIEVE VISION CAN BE RESTORED IN WHOLE OR IN PART BY TREATMENT OR SURGERY? Yes No
IF SURGERY IS CONTEMPLATED, GIVE NATURE AND APPROXIMATE DATE: _____

4. IN YOUR OPINION, WAS ANY DISEASE, INFECTION, OR BODILY OR MENTAL INFIRMITY, AN UNDERLYING OR CONTRIBUTING CAUSE IN THE LOSS(ES) INDICATED ABOVE? Yes No

IF YES, PLEASE EXPLAIN _____

5. IN YOUR OPINION, DID THE LOSS(ES) RESULT FROM ANY INTENTIONAL SELF-INFLICTED INJURY OR ATTEMPTED SELF-DESTRUCTION? Yes No

6. WAS THE PATIENT CONFINED TO A HOSPITAL AS A RESULT OF THE LOSS? Yes No

IF YES, NAME AND ADDRESS OF HOSPITAL _____

PLEASE ATTACH COPIES OF YOUR OFFICE RECORDS IN CONNECTION WITH THIS ACCIDENTAL INJURY

PHYSICIANS NAME (Please print) _____ OFFICE TELEPHONE _____

ADDRESS _____

PHYSICIAN'S SIGNATURE _____ DEGREE _____ DATE _____

Insured or Authorized Representative: Sign this form and return with the claim form to:

Attention: Co-ordinated Benefit Plans, LLC
On Behalf of Nationwide Mutual Insurance Company and Affiliated Companies
P.O. Box 26222
Tampa, FL 33623

Or E-mail your information to: NWTravClaims@cbpinsure.com Or Fax to: 800-560-6340

Please keep a copy of this form for your records.

AUTHORIZATION FOR USES AND DISCLOSURES OF MEDICAL INFORMATION

To: Nationwide Mutual Insurance Company and affiliated companies ("Insurer")

I hereby give Insurer permission to obtain, use and/or disclose the below Insured's personal health information as follows:

- This authorization was prepared at the request of Insurer for the purpose of evaluating contestability and/or eligibility for benefits.
- The information that is the subject of this authorization and which will be used or disclosed as set forth below includes the release of **all medical records** (except psychotherapy notes), including, but not limited to, those containing medical history, diagnoses, symptoms, treatments, prescription drug information alcohol or drug or tobacco use or abuse or information regarding communicable or infectious conditions, such as AIDS.
- The following person(s) or group of persons employed or working for, or on behalf of Insurer may obtain, use or disclose the Insured's personal health information which is described above: Any physicians, medical practitioners, hospitals, clinics, medical or medically related facilities, paramedic facilities, treatment or recovery centers, governmental agencies, insurance support organizations, medical record retrieval services, pharmaceutical services, plan administrators, insurance companies, reinsurers, independent medical consultant or counsel and consumer reporting agencies such as the Medical Information Bureau.
- I understand that if the person or entity that gives or receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Insurer in reliance on this authorization, by sending a written revocation to: Nationwide Claims Administration, P.O. Box 6866, Shawnee Mission, KS 66206
- I understand that I am not required to sign this authorization form and that Insurer will not condition the provision of payment of benefits on the signing of this authorization, except that Insurer may condition evaluating contestability or insurance coverage eligibility for benefits on provision of this authorization if the authorization sought is for insurance coverage contestability evaluation or insurance coverage eligibility relating to the Insured. This authorization will expire 24 months from the date this authorization is signed.

Insured's Name (Print)

Insured's Date of Birth

Authorized Representative's Name (Print)

Relationship to Insured

Signature of Insured or Authorized Representative

Date

Nationwide® Privacy Statement

Thank you for choosing Nationwide

Our privacy statement explains how we collect, use, share, and protect your personal information. So just how do we protect your privacy? In a nutshell, we respect your right to privacy and promise to treat your personal information responsibly. It's as simple as that. Here's how.

Confidentiality and security

We follow all data security laws. We protect your information by using physical, technical, and procedural safeguards. We limit access to your information to those who need it to do their jobs. Our business partners are legally bound to use your information for permissible purposes.

Collecting and using your personal information

We collect personal information about you when you ask about or buy one of our products or services. The information comes from your application, business transactions with us, consumer reports, medical providers, and publicly available sources. Please know that we only use that information to sell, service, or market products to you.

We may collect and use the following types of information:

- Name, address, and Social Security number
- Assets and income
- Account and policy information
- Credit reports and other consumer report information
- Family member and beneficiary information
- Public information

Sharing your information for business purposes

We share your information with other Nationwide companies and business partners. When you buy a product, we share your personal information for everyday purposes. Some examples include mailing your statements or processing transactions that you request. You cannot opt out of these. We also share your information where federal and state law requires.

Sharing your information for marketing purposes

We don't sell your information for marketing purposes. We have chosen not to share your personal information with anyone except to service your product. So there's no reason for you to opt out. If we change our policy, we'll tell you and give you the opportunity to opt out before we send your information.

Using your medical information

We sometimes collect medical information. We may use this medical information for a product or service you're interested in, to pay a claim, or to provide a service. We may share this medical information for these business purposes if required or permitted by law. But we won't use it for marketing purposes unless you give us permission.

Accessing your information

You can ask us for a copy of your personal information. Please call the number on your insurance ID card if applicable, contact your customer service representative, or send a letter to the address below and have your signature notarized. This is for your protection so we may prove your identity. We don't charge a fee for giving you a copy of your information now, but we may charge a small fee in the future.

We can't update information that other companies, like credit agencies and third parties, provide to us. So you'll need to contact these other companies to change and correct your information.

Send your privacy inquiries to the address below. Please include your name, address, and policy number. If you know it, include your agent's name and number.

CBP
Attn: Privacy Officer
P.O. Box 20594
Tampa, FL 33622-0594

A parting word ...

These are our privacy practices. They apply to all current and former clients of Nationwide Specialty Insurance. They also apply to joint policy or contract holders. This includes the following companies:

Nationwide Life Insurance Company
Nationwide Mutual Insurance Company
National Casualty Company
Allied Property and Casualty Insurance Company



NATIONWIDE® HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the “Notice”) applies to Nationwide¹ and describes the legal obligations of Nationwide, and your legal rights regarding your protected health information held by Nationwide under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Among other things, this Notice describes how your Protected Health Information (“PHI” as that term is defined below) may be used or disclosed to carry out treatment, payment, or healthcare operations, or for any other purposes that are permitted or required by law.

Nationwide is required by HIPAA and certain state laws to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice so long as it remains in effect. Nationwide reserves the right to change the terms of this Notice and to make the new Notice effective for all PHI maintained by us, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of the revised Notice by mail to your last-known address on file.

Protected Health Information (PHI) includes individually identifiable health information that is created or received by Nationwide and that relates to: (1) your past, present, or future physical or mental health or condition, (2) the provision of health care to you, or (3) the past, present, or future payment for the provision of health care to you. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your Authorization. Certain uses and disclosures of PHI require your authorization. For example, most uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI require a written authorization. Except as outlined below, we will not use or disclose your PHI without your written authorization. If you have given us an authorization, you may revoke it in writing at any time, unless we have already acted on the authorization. Once we receive your written revocation, it will only be effective for future uses and disclosures.

Disclosures for Treatment, Payment or Health Care Operations. We may use or disclose your PHI as permitted by law for your treatment, payment, or health care operations. For instance, for your treatment, a doctor or health facility involved in your care may request information we hold in order to make decisions about your care. For payment, we may disclose your PHI to our pharmacy benefit manager for administration of your prescription drug benefit. For health care operations, we may use and disclose your PHI for our health care operations, which include responding to customer inquiries regarding benefits and claims.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your PHI to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person’s involvement in caring for you or paying for your care.

If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited PHI with such individuals without your approval.

¹ Nationwide Life Insurance Company®, National Casualty Company and the area within Nationwide Mutual Insurance Company® that performs healthcare functions.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations. For example, we may disclose your PHI to a business associate to administer claims or to provide support services. In all cases, we require these business associates by contract to appropriately safeguard the privacy of your information.

Other Health-Related Products or Services. We may, from time to time, use your PHI to determine whether you might be interested in or benefit from treatment alternatives or other health-related programs, products, or services which may be available to you as a member of the health plan. For example, we may use your PHI to identify whether you have a particular illness, and advise you that a disease management program to help you manage your illness better is available to you. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

Plan Administration. We may release your PHI to your plan sponsor for administrative purposes, provided we have received certification that the information will be maintained in a confidential manner and not used in any other manner not permitted by law.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your PHI without your authorization. We may release your PHI for any purpose required by law. This may include releasing your PHI to law enforcement agencies; public health agencies; government oversight agencies; workers compensation; for government audits, investigations, or civil or criminal proceedings; for approved research programs; when ordered by a court or administrative agency; to the armed forces if you are a member of the military; and other similar disclosures we are required by law to make.

OTHER PRIVACY LAWS AND REGULATIONS

Certain other state and federal privacy laws and regulations may further restrict access to and uses and disclosures of your personal health information or provide you with additional rights to manage such information. If you have questions regarding these rights, please send a written request to your designated contact as explained in the "Contact Information" section, below.

RIGHTS THAT YOU HAVE

Access to Your PHI. You have the right to copy and/or inspect much of the PHI that we retain on your behalf. All requests for access must be made in writing and signed by you or your personal representative. We may charge you a fee if you request a copy of the information. The amount of the fee will be indicated on the request form. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Amendments to Your PHI. You have the right to request that the PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. If the information is incorrect or incomplete and we decide to make an amendment or correction, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. A request form can be obtained by writing to your designated contact at the address provided in the "Contact Information" section.

Accounting for Disclosures of Your PHI. You have the right to receive an accounting of certain disclosures made by us of your PHI. Requests must be made in writing and signed by you or your personal representative. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Restrictions on Use and Disclosure of Your PHI. You have the right to request restrictions on some of our uses and disclosures of your PHI. We will consider, but are not required to agree to, your restriction request. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Request for Confidential Communications. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your PHI information from us by alternative means or at alternative locations. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Right to be Notified of a Breach. You have the right to be notified in the event we discover a breach of your unsecured PHI.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice, even if you have requested such copy by e-mail or other electronic means.

Complaints. If you believe your privacy rights have been violated, you can file a written complaint with your designated contact as explained in the "Contact Information" section, below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have any questions about this Notice, need copies of any forms or require further assistance with any of the rights explained above, contact us by calling 1-800-753-1000, x329 or mail your request to:

Co-ordinated Benefit Plans, LLC.
Attn: Privacy Officer
18167 US Highway 19 North
Suite 180
Clearwater, FL 33764

EFFECTIVE DATE

This Notice is effective 9/15/2015

Nationwide, the Nationwide framework, and On Your Side are federally registered service marks of Nationwide Mutual Insurance Company.

NH-0524-H-09152015

FRAUD STATEMENTS – If you reside in the state of:

General: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

District of Columbia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents a 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.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Missouri: An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.”

All Other States: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

EFFECTIVE DATE

This Notice is effective May 16, 2014.