HOSPITAL CONFINEMENT INDEMNITY
SUPPLEMENTAL CLAIM QUESTIONNAIRE

Claimant's Name: ______________________________

Address: ______________________________

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Policy #: BB200218 Social Security #: ______________ Date of Birth: __________

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

Name of Provider/Physician: ______________________________

Address: ______________________________

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Date of Service: ______________________

Please describe symptoms for which you were seeking treatment: ______________________

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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? ______________

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

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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: **90 Degree Benefits**
2810 Premiere Pkwy, Ste 400 Duluth, GA 30097
Fax: (678) 258-8299 / Email: claims.t5a@90DegreeDenefits.com
www.90DegreeBenefits.com
Phone: (800) 239-3503 - Monday through Friday - 8:30 a.m. to 5:00 p.m. EST