State Mutual Insurance Company
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Platinum® SUPPLEMENTAL INSURANCE

CONTINUATION CLAIM FORM

PLEASE NOTE: This claim form is designated for continuing a claim that has previously been submitted to us. It is important that all questions be answered in full and that this form be returned to the company. Failure to complete all sections may result in a delay in processing this claim. If patient is a minor, questions should be completed by the Insured.

1. Policy Number _____
2. Policyholder's Name _____
3. Patient's Name (if other than Policyholder) _____
4. Patient's Date of Birth _____/ _____/ _____
5. Address_____
   Street City State Zip
   a) If this is a permanent address change, please check here ☐
6. Phone number (_____) _____
7. Type of claim: ☐ Cancer ☐ Heart Attack/Stroke ☐ Chronic Illness ☐ Accident ☐ Other _____
8. What was the first date of service for this claim? _____/ _____/ _____
9. Was the patient transported to a medical facility by air or ground ambulance? ☐ Yes ☐ No
10. Was the patient confined to a hospital for this condition? ☐ Yes ☐ No
    a) Date of confinement: _____/ _____/ _____ to _____/ _____/ _____
    b) Was the patient confined to an Intensive Care Unit (ICU)? ☐ Yes ☐ No
11. Was surgery performed as a direct result of this condition? ☐ Yes ☐ No
    a) Type of surgery and date: _____
12. Did the patient receive chemotherapy or radiation as a direct result of this condition? ☐ Yes ☐ No
13. Did the patient travel over 50 miles from home to receive treatment for this condition? ☐ Yes ☐ No
14. Was the patient confined to a skilled nursing facility (SNF) for this condition? ☐ Yes ☐ No
    a) Date of confinement: _____/ _____/ _____ to _____/ _____/ _____

I understand that this information will be used by State Mutual Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

_____ _____ _____
Name of Patient Signature of Patient Date Signed (MM/DD/YYYY)

If Patient is under eighteen (18) years of age or is incapacitated, Parent or Guardian must sign. IF PATIENT IS DECEASED, Personal Representative or Next of Kin must sign. The Furnishings of the Form is not admission of any Liability on the part of the Company.