NOTIFICATION OF CLAIM FORM

___50% Notification/Trigger Dx ___ Initial Submission

To: Kismet Risk Management Associates
Email: potentials@kismetrisk.com

From: ____________________________ Date: ______________________________

____________________________ Phone #: ____________________________

____________________________ E-mail: _____________________________

____________________________ Effective Date: ___________________

Policyholder: ____ Expiration Date: __________________

Policy #:__________________ Specific Deductible: $___________________

Employee: _________________________________ DOB: ____________ SS#: ______________________________

Claimant: ______________________________________ Sex: _____ Relationship: ___________ DOB: __________

EE Effective Date w/Employer: _________________ EE Date of Hire: _____________ EE Term. Date: ______________

Dep. Effective Date: ___________________ Dep. Term. Date: ____________________

Is COBRA Applicable? Yes ____ No ___ If yes, Eff. Date: _______________ Termination Date: ________________

Employee Actively at Work on the effective date: Yes ___ No ___ If no, date last worked: _______________________

Nature of Illness of Injury (Diagnosis): ________________________________ Date of onset: ____________________

If Injury, when, where, and how did it occur? ____

Prognosis: ____

Physician: ___________________ Address: _________________________________ Tel. #: _____________________

Date first Charge Incurred: ______________ Date Last Charge Incurred: _____________ Total Amount Paid to Date: _________ Estimate of Total Claim: __________

Is claimant covered under any other group insurance? Yes ____ No ___ If yes, Auto/No Fault: ______________________

Medicare: _____________ Workers' Comp: _______________ Other (Insured & Type of Coverage): _________________

Is Subrogation applicable? Yes ____ No ___ If yes, has Subrogation Agreement been filed? Yes ____ No ____

Briefly comment on any Pre-screening, Auditing, or Medical Case Management performed (attach reports):

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Prepared by: ______________________________________ Print Name: ______________________________________

This form must be completed in full for all Initial Submissions only. The Specific Claim Reimbursement Form must be completed for both Initial and Subsequent Submissions.