NATIONAL SECURITY INSURANCE COMPANY
ELBA, ALABAMA 36323

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

INSTRUCTIONS FOR FILING WELLNESS CLAIMS

- To avoid delays in processing please fill out the sections which apply to your specific claim.
- Include your policy number. If you need to obtain your policy number please call **1-800-798-2515** for assistance.
- You may **fax** your claim to us at **1-800-693-7507**. Please be assured that your claim will receive our prompt attention. You will usually receive a response from us in the mail within 10 business days following the receipt of your claim. The length of time in the mail will depend on your location.
- You may mail your claim to: **National Security Insurance Company**
  P. O. Box 703
  Elba, Alabama 36323

If you have a question regarding your claim you may reach the Claims Department at 1-800-798-2317.

POLICYHOLDER / INSURED

NAME: _____ Policy Number(s) _____

Your Mailing Address: _____

City: _____State: _____ Zip: _____

Date of Birth: Month: _____ Day: _____ Year: _____ Social Security Number: _____

Home Telephone Number: _____ Work / Cell Number: _____

WELLNESS EXAM

INSTRUCTIONS FOR FILING WELLNESS CLAIMS:

□ Please attach the physician, clinic, or facility receipt showing the specific wellness exam performed, the date it was performed and the charge for the exam. Thank you**.**

Important: To avoid delay, please sign authorization below.

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to National Security Insurance Company (NSIC) any information relating to my claim. A copy of this authorization is as valid as the original. This authorization applies to any dependent on which a claim is filed. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying NSIC in writing of my desire to do so. I or my representative may receive a copy of this authorization by supplying policy number(s) and insured's name in a written request to the company.

Signed here: _____ Date: _____ □ Check here if address is new
Claimant

Mailing Address: _____ City: _____ State: _____ Zip: _____

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY"