Nursing Home Waiver Claim Form

Member Name: _____

Policy Number: _____

Nursing Home Information

Address: _____

City, State, Zip Code: _____

Phone Number: _____ Fax Number: _____

Date of Admission: _____ Monthly Charge: _____

Doctor Name: _____

MANDATORY

Please attach an attending physician statement certifying resident's condition and that admission was necessary and continuous for at least 60 days

My signature below indicates my authorization for the Nursing Home Named Above to submit bills to KSKJ Life and for KSKJ Life to make payments on my behalf out of my Annuity directly to the nursing home. This Agreement will continue until I notify KSKJ Life in writing of any changes.

_____ _____

Member Signature/POA* Date Member Name Printed

**If a POA is signing please provide a copy of the POA papers*

_____ _____

Doctor Signature Date Doctor Name Printed

_____ _____

Nursing Home Administrator Signature Nursing Home Administrator Printed