Accident and Health

CLAIMANT'S STATEMENT

American Public Life Insurance Company

P O Box 925 ♦ Jackson MS 39205-0925 ♦ 1-800-256-8606

Name of Claimant	SS #	Policy/Certificate #
Street Address or P O Box	City, State and Zip	
Date of Birth	Relationship to Primary Insured	Telephone #
Name of Primary Insured	SS #	Primary Insured's Employer
Is this claim due to an accident?	Will a Worker's Comp claim be filed?	
Describe Illness/Injury. If injury, how did it occur?		

**IMPORTANT: SUBMIT A COPY OF THE POLICE REPORT IF CLAIM IS DUE TO A VEHICLE ACCIDENT.
SUBMIT A COPY OF THE PATHOLOGY REPORT IF CLAIM IS DUE TO CANCER.**

Were you hospitalized? Where?	Dates of hospitalization From / / to / /
Have you ever had symptoms of this condition before? When?	

Names and addresses of Attending Physicians (if necessary, list on separate piece of paper and attach):

Name	Address
______________________	______________________________
______________________	______________________________

FOR DISABILITY CLAIMS ONLY Date you returned or will return to work ____________

Date you stopped working due to disability ____________ Average Monthly Earnings ____________

List job duties:

WARNING - AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. **CA**: For your protection California law requires the following to appear on this form. Any person who knowingly presents a 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. **CO**: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **DC**: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant. **FL**: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **KY**: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **ME**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **MA**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **MN**: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. **NJ**: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **NM**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **OH**: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **PA**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **VA**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **WA**: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. **ALL OTHER STATES:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

BY SIGNING BELOW I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

______________________	______________________	____________
Primary Insured Signature	**Claimant Signature**	**Date Signed**

EMPLOYER'S STATEMENT: FOR DISABILITY OR WAIVER OF PREMIUM CLAIMS ONLY

1. Date of first absence due to disability	2. Date employee returned to work
3. Date hired	4. Date of termination if terminated
5. Date of retirement if retired	6. Did employee take disability retirement?

7. REQUIRED: If the employee pays the premium for this plan through payroll deduction, is the premium sheltered under a Section 125 (cafeteria) plan? ___________ Is the premium paid by the employer as an employee benefit? ___________

8. Has claim or will claim be made for Worker's Compensation Benefits? _________If yes, what is the status of the claim?

9. Will you provide "light duty" if employee is released with restrictions?

10. Employer Name	11. Employer Telephone #

Authorized Signature	**Title or Position**	**Date**

ATTENDING PHYSICIAN'S STATEMENT: **For routine FIRST-AID claims, this side is not usually required if a copy of the bill showing Patient's name, diagnosis, charges and date incurred is furnished along with Claimant's Statement on reverse side.**

1. Diagnosis and concurrent conditions. **ICD-9 CODES REQUIRED:**

2. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No	3. If condition is due to an accident, give details of the accident:

4. Is condition due to pregnancy? ☐ Yes ☐ No If yes, expected delivery date: ___________ Date of LMP ___________

5. Report of Services (or attach itemized bill):

Date of Service	CPT Code	Description of Medical Service Rendered	Charge
___________	_________	______________________________	$ ________
___________	_________	______________________________	$ ________
___________	_________	______________________________	$ ________
___________	_________	______________________________	$ ________

6. Date symptoms first appeared or accident happened	7. Date patient first consulted you for this condition
8. Has patient ever had same or similar condition? ☐Yes ☐No If "yes", when and describe:	9. Patient still under your care for this condition? ☐ Yes ☐ No Date last seen: ___________________________
10. Patient was continuously and totally disabled (unable to perform substantially all of his/her occupational duties) From___________________Through ____________________	11. Patient was partially disabled (able to perform some but not all of his/her occupational duties) From___________________Through_______________
12. If still disabled, date patient should be able to return to work?	13. Patient was hospital confined From___________________Through ____________________
14. Does patient have other health coverage? If "Yes", please identify:	15. Was patient referred to you by another physician"? ☐Yes ☐No If "Yes", please provide name of referring physician:

Physician's Name (Please Print)	Degree	IRS Identification Number

Address	Phone Number
Physician's Signature	**Date**

American Public Life Insurance Company

A member of the American Fidelity Group

2305 Lakeland Drive, Jackson, Mississippi 39232
(601) 936-6600 • (800) 256-8606

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize any physician or practitioner of the healing arts, hospital, clinic or medically related facility, pharmacy, insurance company, health maintenance organization, medical information bureau, Worker's Compensation carrier, Social Security office, Veterans Administration, retirement system, government entity (federal, state or local) or other organization, institution or person to release any information regarding the medical or mental health history, treatment, disability or benefits payable for medical care or disability to the American Public Life Insurance Company or its representative. A photocopy of this authorization shall be as valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed, except release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from date signed. I understand that this authorization may be revoked at any time by providing written notice to American Public Life Insurance Company ***except to the extent that American Public Life has taken action in reliance of this authorization or to the extent that law allows American Public Life to contest claims or coverage. Written notice must refer to the authorization by indicating the date it was signed and should be mailed to APL Claims Department, P O Box 925, Jackson MS 39205-0925.*** By signing below I certify the above information as true and CORRECT to the best of my knowledge.

American Public Life may use this information to determine what, if any, benefit can be provided for any American Public Life coverage for which I may be eligible.

By State Law, you must be advised that:
THE INFORMATION YOU AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME ("AIDS").

The information you authorize for release may include your history of treatment for physical and/or emotional illness to include psychological testing (but not psychotherapy notes) and treatment records of alcohol and drug abuse.

You do have the right to refuse to sign this authorization; however, failure to sign the authorization may result in a denial of benefits.

American Public Life Insurance Company and its reinsurers agree to maintain the confidentiality of all the Insured's nonpublic financial or medical information given to us by any authorized entities listed above***; however, federal law (HIPPA) requires you be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and is no longer protected by HIPPA rules.***

Signature:______________________________ Date: ________________

Print Your Name:______________________ Name of Claimant:________________

If a personal representative signs this authorization, a description of the authority to act on behalf of the Insured must be included.

RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR PERSONAL RECORD.