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
PO Box 925, Jackson MS 39205-0925 • Toll Free Fax (877) 365-9423 • Toll Free Telephone (800) 256-8606

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Public Life Insurance Company (APL) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacies; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles; and k) Workers' Compensation Carriers. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. For Maine residents, information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, AIDS/ARC (Acquired Immune Deficiency Syndrome/AIDS Related Complex) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS. For Vermont residents, this authorization does not require disclosure of prior HIV-related tests. For Wisconsin residents, results of AIDS/HIV test do not need to be reported if they were done at any anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or a delay of benefits. I understand that I may revoke this authorization at any time by writing to APL South Claims Department, PO Box 925, Jackson MS 39205-0925 or by calling, toll-free, 1-800-256-8606. I understand that my right to revoke this authorization is limited to the extent that: action has been taken in reliance on the authorization; or the law provides the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

Signature (Patient) or Personal Representative (if applicable) Printed Name (Patient)

Date of Birth Date Signed

I certify this information is true and correct.

Relationship of Personal Representative to Patient _____

If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.

Please retain a copy for your personal records, or you may request a copy from our Company.

Certain products administered by American Public Life Insurance Company are underwritten by American Fidelity Assurance Company.