LIFESECURE INSURANCE COMPANY
ADMINISTRATIVE OFFICE
ATTN: Claims Department
PO Box 1420, Brighton, MI 48116
1-888-575-8246

| Accident Claim Form |

Instructions for Filing a Claim

- Please have all sections of this form fully completed to avoid delays in the processing of your claim:
  - Section A: Must be completed by the **policyholder/certificateholder**.
  - Section B, C and D: Must be completed by the **claimant** (or legal guardian if under the age of 18). **The claimant must sign and date the statement at the bottom of page 2 and the Claimant Authorization on page 6.**
  - Section E: Must be completed by the **physician** who initially treated the claimant for this accident. If the claimant was initially treated in a hospital emergency room, you may instead submit a copy of the emergency room physician's report which can be obtained from the treating hospital. If initially treated in a physician's office or urgent care center, you may submit the physician's office or urgent care center records and notes pertaining to the visit.
  - Section F: Must be completed and signed by the **policyholder/certificateholder** if he or she requests benefit payments to be directly deposited in his or her banking account.
- **Submit copies of all bills relating to this claim, such as hospital, emergency room, ambulance and physician office visit bills. All bills must include the diagnosis, and must show a complete itemization of all services rendered and the individual charge for each service. Bills that show only a summary of services and charges cannot be accepted.**
- **For each bill, we require a copy of the corresponding Explanation of Benefits (EOB) from your primary health insurance.**
- We require a copy of the police accident report and toxicology report (if applicable) for injuries due to motor vehicle accidents and any other incidents investigated by a law enforcement agency.
- Mail your claim to the above address, fax to 877.226.7315, or send electronically using your secure Personal Web Portal at www.YourLifeSecure.com (select "Policyholders" from the login menu). Your claim form, bills and EOBs must be submitted to us within 120 days from the date of loss (**NC:** 180 days; **HI:** 450 days). You do not need to wait until all bills and EOBs are received to begin sending your claim.

Section A: Policyholder/Certificateholder Information

First Name _____ MI _____ Last _____

Date of Birth (mm/dd/yyyy) _____ Policy No./Certificate No. _____

Street Address (P.O. Boxes cannot be accepted) _____ City _____ State _____ Zip _____

Home Telephone No. _____ Work Telephone No. _____

Section B: Claimant Statement

First Name _____ MI _____ Last _____

Date of Birth (mm/dd/yyyy) _____ Relationship (Self, Spouse, Child, Other) _____

Street Address (P.O. Boxes cannot be accepted) _____ City _____ State _____ Zip _____

Home Telephone No. _____ Work Telephone No. (if applicable) _____

Section B: Claimant Statement (continued from page 1)

Date of accident: _____/_____/_____ Time of accident: _____ ☐ a.m. ☐ p.m.

Location of accident (give exact address or nearest cross streets): _____

_____

Describe how the accident occurred and the nature of the injury:

_____

_____

_____

_____

_____

_____

Date of initial treatment by a hospital, emergency room, urgent care center or physician: _____/_____/_____

Section C: Attending Physician Information

_____ _____

Name of Attending Physician | Phone No.

_____ _____

Street Address | City State Zip

Section D: Hospital, Emergency Room, or Urgent Care Center Information (if applicable)

_____

Name of Facility

_____ _____

Street Address | City State Zip

_____ _____

Date Admitted (mm/dd/yyyy) | Date Discharged (mm/dd/yyyy)

I certify that I have read and understand the fraud warning specific to my state as presented in this document.

_____ _____

➡ **CLAIMANT SIGNATURE** (To be signed by claimant or legal guardian if under age 18) ➡ **DATE**

Section E: Attending Physician's Statement for Accidental Injury

To be completed only by the physician who initially treated the claimant for this accident. ***If the claimant was initially treated in a hospital emergency room, you may instead submit a copy of the emergency room physician's report which can be obtained from the treating hospital. If initially treated in a physician's office or urgent care center, you may submit the physician's office or urgent care center records and notes pertaining to the visit.***

Patient Information

Patient Name | Date of Birth (mm/dd/yyyy)

Physician Information

Physician Name (please print) | Tax ID No.

Phone No. | Fax No.

Street Address | City | State | Zip

Physician Statement

Diagnosis | Is diagnosis the result of an accident? ☐ Yes ☐ No

Date of Accident (mm/dd/yyyy) | Date of Initial Treatment for Accident (mm/dd/yyyy)

Please describe how and where the accident occurred:

Was patient hospitalized or treated in an emergency room or urgent care center for this accident? ☐ Yes ☐ No

Date of Admission (mm/dd/yyyy) | Date of Discharge (mm/dd/yyyy)

Facility Name | City | State | Zip

Was patient referred to you by another physician? ☐ Yes ☐ No

Physician Name (please print) | Phone No.

Street Address | City | State | Zip

➡ PHYSICIAN SIGNATURE ➡ DATE

Section F: Electronic Funds Transfer Information

Any benefits payable for this claim will be paid to the primary policyholder/certificateholder, regardless of claimant. If the policyholder/certificateholder wishes benefits payable for this claim be deposited directly to his or her checking or savings account, please provide the following information. If the policyholder/certificateholder prefers to be paid via a check by mail instead, please leave this section blank.

Name of Bank _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Account Type: ☐ Checking ☐ Savings

Account Number _____ Routing Number _____

➡ POLICYHOLDER/CERTIFICATEHOLDER SIGNATURE _____ ➡ DATE _____

MEDICAID ELIGIBILITY: Your current or future eligibility for Medicaid may affect the payment of benefits provided by this Policy. State regulations may require payments be made to the Medicaid organization or to the medical provider and not you.

Fraud Warning:

For All States Not Listed Separately Below: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Alabama**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

To residents of **Alaska**: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

To residents of **Arkansas, Louisiana, Oregon, Rhode Island & West Virginia**: 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.

To residents of **Arizona**: 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.

To residents of **California**: For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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.

To residents of **Colorado**: 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/Certificateholder or claimant for the purpose of defrauding or attempting to defraud the Policyholder/Certificateholder 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.

To residents of **DC: WARNING 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.**

To residents of **Delaware & Idaho**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

To residents of **Florida**: 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.

To residents of **Indiana**: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

To residents of **Kentucky**: 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.

To residents of **Maryland**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

To residents of **Minnesota**: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

To residents of **New Mexico**: Any person who knowingly presents a false or fraudulent claim for payment of a loss of 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.

To residents of **Ohio**: 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.

To residents of **Oklahoma: WARNING** – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

To residents of **Pennsylvania**: 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.

To residents of **Tennessee, Virginia & Washington**: 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.

To residents of **Texas**: 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.

LIFESECURE INSURANCE COMPANY
Administrative Office
P.O. Box 1420
Brighton, MI 48116

| Claimant Authorization to Obtain and Disclose Information |

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, insurance company, or insurance support organization that has such information, to disclose the following health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS) or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, and any reinsurers. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask LifeSecure to correct, amend or delete any incorrect personal information

I acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws. A copy of LifeSecure's "Notice of Privacy Practices" is available upon request.

This authorization shall be valid for a period of 24 months from the date signed (**in AZ**, 180 days) (**in VA**, 30 months). A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to LifeSecure's Administrative Office.

Although my signature on this form is voluntary, I understand that it is required to determine my eligibility for benefits under an insurance policy issued by LifeSecure. Without my signature, or upon its revocation, I understand that my claim for insurance benefits may be denied. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws. However, LifeSecure does require its agents and service providers to protect the confidentiality of health information.

My signature below represents my acknowledgement, acceptance and authorization for all statements above.

Claimant's Name: _____ **Date of Birth:** _____
Print Name

Social Security No: _____

Claimant's Signature: _____ **Date:** _____

(To be signed by claimant unless under age 18)

Signature of Legal Guardian (if claimant is under age 18): _____ **Date:** _____

Print Name of Legal Guardian (if signing for claimant above): _____

Relationship to claimant: _____
Legal Guardian Address and Phone No: _____

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Optional Claimant Authorization to Release Information Regarding this Claim

Please initial below in the spaces provided if you wish to allow us to release information to a particular entity inquiring about this claim on your behalf. Any other marks used *(check mark, X, etc…)* cannot be accepted and will be processed as if blank. Leave blank if you do not want us to release any information to a particular entity. You must also sign and date this page in the spaces provided below.

I authorize LifeSecure Insurance Company and its Administrative Office to facilitate the processing of this claim by releasing its details, including Protected Health Information (PHI), to the following entity or entities inquiring on my behalf:

_____ **Agent**

_____ **Employer Insurance Administrator**

_____ **Spouse/Domestic Partner**

_____ **Other (specify name and relationship):** _____

➡ **CLAIMANT SIGNATURE** (if age 18 or over) ➡ **DATE**

CLAIMANT NAME (please print)

➡ **POLICYHOLDER/CERTIFICATEHOLDER SIGNATURE** (if claimant is under age 18) ➡ **DATE**

POLICYHOLDER/CERTIFICATEHOLDER NAME (please print)

POLICY NO./CERTIFICATE NO.

DATE OF ACCIDENT (mm/dd/yyyy)