Filing an Assurity at Work® Accident Expense Claim

Assurity at Work Accident Expense insurance coverage provides a fixed cash benefit for medical treatments associated with a covered accident.

This document lists the forms and evidence required for submission of a claim for benefits. Additional information may be necessary to determine benefit eligibility and may require Assurity to order medical records. The required forms listed below can be accessed in the Customer Service Center on www.assurity.com or by contacting Assurity's Claims Department at **(800) 869-0355, Ext. 4484**.

Proof of Claim may be required within 12 months of the time of loss. Assurity administers many different plans of insurance. Your policy may not include all of the benefits detailed below. Please consult your contract for specific benefits, definitions, provisions, limitations and exclusions.

Medical Treatment Benefits	
	Information Needed/Required Proof for Claim
	1) Claimant Statement form #75-010-02283F; ***and*** 2) Copy of Accident Report if available; ***and*** 3) Itemized bill detailing covered treatment or procedure; Acceptable itemized bill must include the following: dates of service, diagnostic codes (ICD-9 or ICD-10), procedure codes (CPT) and amount charged. (HCFA 1500 form and/or UB-04 form obtained from medical provider should include all required information.) ***and*** 4) Confidential Information Authorization form – to be completed by claimant. The following list shows the appropriate authorization form number for the state in which the claimant resides: 75-500-05055 All states not listed below 48-500-05055 (AZ) 69-500-05055 (MN) 73-500-05055 (NC) 49-500-05055 (CA) 67-500-05055 (ME) 92-500-05055 (VA) 94-500-05055 (VT) Depending on the documentation provided in 1), 2) and 3) above, Assurity may need to acquire additional medical records. If needed, having a signed authorization on file will expedite the processing.
Additional Benefits	
Potential Benefit	***Information Needed/Required Proof for Claim***
• Accidental Death • Dismemberment • Loss of Use	Please contact Assurity's claims department at **(800) 869-0355, Ext. 4484** for claim filing requirements.
Riders listed below are available for some Assurity Accident Expense products but are not necessarily a part of your contract. Please review your contract to verify any riders you may have selected.	
Additional Rider Benefits	
Potential Benefit	***Information Needed/Required Proof for Claim***
• Disability Income Rider • Loss of Time	Please see instructions and forms for filing a disability income claim.

If your contract includes benefits not described in this document or you have questions, please contact Assurity's Claims Department at **(800) 869-0355, Ext. 4484**.

15-373-02283

Assurity®
Life Insurance Company
PO Box 82533 • Lincoln, Nebraska 68501-2533

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(800) 869-0355, Ext. 4484 • Fax (800) 869-0368

Accident Expense Claim Form
CLAIMANT STATEMENT

If your policy includes the Short-Term Disability Income rider or Loss of Time benefits and you wish to file a disability claim, please refer to Disability Income claim forms.

Your policy may not include all of the benefits listed below. Please consult your policy language for provisions and policy specific benefits.

Some policies require proof of the amount charged for the services performed. This information can be obtained from the patient's healthcare provider(s) by requesting an itemized bill, HCFA 1500 non-hospital bill or a UB04 hospital bill. If proof of the amount charged is not provided when required by the policy, the claim may be delayed or denied. We will contact you if the itemized bill is required and not received.

First *Middle* *Last*	
1. Policyowner's name	Policy no.
Street address *City* *State* *ZIP+4*	
Address	
Phone no. ( )	Social Security no. ☐ Male ☐ Female Policyowner's date of birth *MM/DD/YYYY*
First *Middle* *Last*	*(MM/DD/YYYY)*
2. Name of claimant *(if other than Policyowner)*	Date of birth
3. Occupation	Employer's contact no. ( )
Name *Street address* *City* *State* *ZIP+4*	
4. Employer	
5. Date your physician first treated you *(MM/DD/YYYY)*	Other dates of treatment
6. Date of the accident *(MM/DD/YYYY)*	Time of day ☐ a.m. ☐ p.m.
7. Did the accident happen at work? ☐ Yes ☐ No	**Please provide a copy of the accident report.**
8. Please provide a brief description of the accident _____	

9. **This claim form must be accompanied by an itemized bill** *(showing date of service, diagnosis and procedure codes).*
Please check benefit(s) you are applying for:

☐ Ambulance *(Air or Ground)*	☐ Accident Emergency Treatment	☐ Appliance	☐ Blood/Plasma/Platelets
☐ Burn	☐ Dislocation	☐ Emergency Dental Work	☐ Emergency Room Treatment
☐ Eye Injury	☐ Follow-up Treatment	☐ Gunshot Wound	☐ Lodging *(lodging bill, companion name)*
☐ Hospital Confinement	☐ Laceration	☐ Major Diagnostic Exam	☐ Physician's Office Visit/Urgent Care
☐ Prosthetics	☐ Physical Therapy	☐ Transportation	☐ Other _____

10. If you are applying for **Accidental Death** or **Common Carrier** benefits, please provide: 1) certified death certificate and 2) motor vehicle or police report.

Claims can be faxed to (800) 869-0368 or mailed to Assurity at the address on the top of this form.

FRAUD NOTICES

Unless specific state language is provided below for your state of residence, the following general fraud notice applies.

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 shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

AL RESIDENTS: 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.

AR, DC, LA, MA, RI RESIDENTS: 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.

Continued on page 2

FRAUD NOTICES *(continued)*

AZ RESIDENTS: 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 RESIDENTS: 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.

CO RESIDENTS: 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.

FL RESIDENTS: 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.

IL RESIDENTS: 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 fraud or intentional misstatements of material fact commits a fraudulent insurance act, which is a crime and subject to a substantial civil penalty where and to the extent allowed by state law.

KS RESIDENTS: 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 may be a crime as determined by a court of law and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

KY RESIDENTS: 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.

MD RESIDENTS: 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.

ME, TN, WA RESIDENTS: 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.

MN RESIDENTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NC RESIDENTS: 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 may also be subject to a substantial civil penalty where and to the extent allowed by state law.

NH RESIDENTS: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information, is subject to prosecution and punishment for insurance fraud.

NJ RESIDENTS: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM RESIDENTS: 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.

NY RESIDENTS: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH RESIDENTS: 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.

OK RESIDENTS: 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.

OR RESIDENTS: Any person who knowingly and with intent to defraud an insurance company or any other person presents a false claim for payment of a loss or benefit may be guilty of insurance fraud and subject to civil fines and criminal penalties. If such misinformation is material to the content of the contract, relied upon by the insurer and either material to the risk assumed by the insurer or provided fraudulently, such action may also lead to denial of insurance benefits.

PA RESIDENTS: 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 RESIDENTS: Any person who, with the intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

VT RESIDENTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I hereby acknowledge that I have read the applicable notice above.

I hereby certify the statements above are complete and accurate to the best of my knowledge.

Signature of Policyowner _____ Date *(MM/DD/YYYY)* _____

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • www.assurity.com

Confidential Information Authorization

_____ / / _____
Legal Name of Applicant/Insured/Claimant (Please print) **Date of Birth** *(MM/DD/YYYY)*

_____ / / _____
Legal Name of Additional Applicant/Insured/Claimant (Please print) **Date of Birth** *(MM/DD/YYYY)*

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

Legal Name	**Date of Birth**	*Legal Name*	**Date of Birth**

I, on behalf of myself or the person named above *(Individual)*, hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. *(formerly known as the Medical Information Bureau)*, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company *(Assurity)*, or its reinsurers, any such information. This may include:

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation)*, occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus *(HIV)* infection and sexually transmitted diseases.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling sessions *(start and stop times)*, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.
- Financial records and information.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted. By this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, MIB Inc., consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health, to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to redisclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twenty-four *(24)* months from the date of signature below ***(authorization to disclose HIV-related information is valid for 180 days from the date of the signature below)***, for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

This authorization complies with the Health Insurance Portability and Accountability Act *(HIPAA)* Privacy Rule.

_____ / / _____
Date (MM/DD/YYYY) *Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*

_____ _____
Signature of Additional Applicant/Insured/Claimant or Legal Representative *Signature of Applicant/Insured/Claimant Child (if age 18 or older)*

_____
Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT