USAble Life℠

ACCIDENT INSURANCE CLAIM FORM

Submit this form and all required documentation for all USAble Life Accident plans.

SUBMIT YOUR CLAIM
Complete all fields and return to USAble Life
Attention: Claims Department
Mail: P.O. Box 1650 | Little Rock | AR | 72203
Email: claims@usablelife.com
Fax: (501) 235-8416

CUSTOMER CARE
(800) 370-5856 Monday-Friday, 8 a.m. to 5 p.m. CST

TYPE OF CLAIM (required section)

☐ **MEDICAL EXPENSE** ☐ **DISABILITY** ☐ **INJURY/LOSS** ☐ **DISMEMBERMENT** ☐ **DEATH**

CLAIM SUBMISSION CHECKLIST (review and ensure you have all that is required for your claim to be processed)

ALL CLAIMS
1. Claim Form (all required sections)
2. Fraud Notice
3. Authorization Statement
4. Supporting Documentation
   - Physician's Statement (admit and discharge summary, emergency room report, and office visit notes)
   - Itemized Billing (copies of medical insurance claim(s) with procedure and diagnosis codes)

MEDICAL EXPENSE CLAIMS
Items 1-4 plus:
- Itemized Hospital Bill(s)
- Itemized Medical Provider(s) Bill(s)

ACCIDENT AND SICKNESS RIDER DISABILITY CLAIMS
Items 1-4 plus:
- Section 4A of this Claim Form

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) RIDER INJURY CLAIMS
Items 1-4 plus:
- Accident/Police Report
- Toxicology Report

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) RIDER DEATH CLAIMS
Items 1-4 plus:
- Section 4B of this Claim Form
- Accident/Police Report
- Toxicology Report
- Death Certificate

SECTION 1: POLICYHOLDER INFORMATION (required section)

Policyholder Name (last, first, middle)		Gender ☐ Male ☐ Female
Address (street, city, state, and ZIP)		
Date of Birth	Social Security No.	Telephone No.
Do you authorize USAble Life to communicate with you by email? ☐ Yes ☐ No		Email Address
Do you authorize USAble Life to leave detailed messages for you regarding this claim at the telephone number provided above? ☐ Yes ☐ No		

SECTION 2: DEPENDENT INFORMATION (required section — if patient is a dependent)

Patient Name (last, first, middle)		Gender ☐ Male ☐ Female
Address (street, city, state, and ZIP)		
Date of Birth	Social Security No.	Telephone No.
Relationship to Policyholder ☐ Spouse ☐ Dependent		
Is the dependent a full-time student? ☐ Yes ☐ No		
If yes, what is the name of the school?		

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SECTION 3: ACCIDENT INFORMATION (required section)	
Describe the accident — what and how did it happen?	
What was the location of the accident?	
What was the date of the accident (month/day/year)?	
What was the name of the physician or hospital the patient was first treated by?	
Physician or Hospital Address (street, city, state, and ZIP)	Telephone No.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: In signing below, I authorize any hospital, physician, medical practitioner, clinic, pharmacy, pharmacy benefits manager, medically related facility, insurance company, DMV, MIB, Inc., and any consumer reporting agency to release any information regarding me or my past or present health to USAble Life, its re-insurers, and legal representatives for the purpose of evaluating this enrollment form for insurance. Information subject to this authorization includes facts about my physical and mental health, advice or treatment; prescriptions; hazardous activities, driving record; age; occupation; income; and my use of alcohol, drugs, and tobacco. This authorization does not authorize the release of genetic screening or testing results. I also authorize USAble Life or its re-insurers to disclose all such information to any physician, or any other insurance company in order to evaluate a claim or an application for insurance. This authorization shall remain valid for a period of two years.

FRAUD WARNING: FOR YOUR PROTECTION, THE LAWS OF SOME STATES MAY REQUIRE US TO FURNISH YOU WITH THE FOLLOWING NOTICE: 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.

I attest to the fact that the information provided is, to the best of my knowledge, complete and accurate.

Signature	Date

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SECTION 4: CLAIM INFORMATION (required section for disability or accidental death claims — employer must complete)		
SECTION 4A: ACCIDENT AND SICKNESS RIDER DISABILITY CLAIMS (employer must complete)		
Employee Name (last, first, middle)		
Date of Birth	Social Security No.	Date of Hire
Employee's Hours Worked (per week)	Date Employee Last Worked	Date Employee Returned to Work
Employer Name		Group Policy No.
Contact Name and Title		
Address (street, city, state, and ZIP)		Telephone No.
Tax ID No.	Fax No.	Email Address
Is the employee considered full time or part time? ☐ Full Time ☐ Part Time		
Does the employee regularly work weekends? ☐ Yes ☐ No		
I attest to the fact that the information provided is, to the best of my knowledge, complete and accurate.		
Signature of Contact		Date
SECTION 4B: AD&D RIDER DEATH CLAIMS (employer must complete)		
Name of Deceased (last, first, middle)		
Address at Time of Death (street, city, state, and ZIP)		
Date of Death	Location of Death	Age at Time of Death
What was the cause of death? ☐ Accidental Injury ☐ Homicide ☐ Other **(provide supporting documentation)**		
Was there an autopsy, inquest, or post mortem examination performed? ☐ Yes ☐ No **(if yes, provide supporting documentation)**		
Relationship to Policyholder ☐ Self ☐ Spouse ☐ Dependent If spouse, was the deceased divorced or legally separated from you at the time of death? ☐ Yes ☐ No If dependent, was the deceased married at the time of death? ☐ Yes ☐ No		
Employer Name		Group Policy No.
Contact Name and Title		
Address (street, city, state, and ZIP)		Telephone No.
Tax ID No.	Fax No.	Email Address
I attest to the fact that the information provided is, to the best of my knowledge, complete and accurate.		
Signature of Contact		Date

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SECTION 5: ATTENDING PHYSICIAN'S STATEMENT (physician must complete)	
Name of Patient (last, first, middle)	
Date of Birth	Social Security No.
Name of Parent/Guardian (last, first, middle) **(required if patient is a minor)**	
Date of Birth	Social Security No.
Date of Accident (month/day/year)	Date of First Visit (month/day/year)
Has patient ever had same or similar condition? ☐Yes ☐No **(if yes, provide date (month/day/year)**	
Diagnosis (must have ICD-10 to process)	
If the accident resulted in dismemberment/loss of a limb, was it through or above the wrist or ankle joint? ☐Yes ☐No ☐N/A	
If the accident resulted in loss of sight, is it permanent or irrecoverable? ☐Yes ☐No ☐N/A	
Was the dismemberment or loss of sight solely due to accidental injury without other causes? ☐Yes ☐No ☐N/A **(if yes, provide date and explain)**	
If the accident resulted in a loss due to a burn, what degree was it? ☐First Degree ☐Second Degree ☐Third Degree ☐N/A If second or third degree burns, what percentage of the body surface was burned?	
If the accident resulted in a loss due to a dislocation, was it a complete separation? ☐Yes ☐No ☐N/A	
If the accident resulted in a loss due to a fracture, please choose one: ☐Simple ☐Compound ☐Open Reduction ☐Closed Reduction ☐N/A	
If the accident resulted in a loss due to a laceration, what was the length of the laceration? ☐<5cm ☐5.08-15.24cm ☐>5.24cm ☐N/A	
What type of repair was performed? ☐Stitches ☐Staples ☐Glue ☐Other ☐N/A	
As a result of the accident, were surgical procedures performed? ☐Yes ☐No **(if yes, provide date and explain)**	
Remarks	
Physician's Name (last, first, middle)	
Physician's Degree	Fax No.
Physician's Address (street, city, state, and ZIP)	Telephone No.
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I attest to the fact that the information provided is, to the best of my knowledge, complete and accurate.	
Signature of Physician	Date

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AUTHORIZATION TO DISCLOSE, OBTAIN, AND USE PERSONAL INFORMATION

In signing below, I represent the statements I may have provided for claim review are true, complete and correct. I hereby authorize third persons, including, without limitation: any financial institution, consumer reporting agency, insurance company or reinsurer, insurance service organization such as the MIB, Inc., benefit plan administrator, health plan, hospital, health care provider, pharmacy, laboratory, business associate, governmental entity (federal, state, or local), or any other organization or individual (collectively "Third Parties"); to disclose the minimum necessary personal, financial and health information, including physical, psychological, psychiatric, drug or substance use and communicable disease diagnosis or treatment information ("Personal Information") to USAble Life (the "Company"), its representatives or agents in connection with underwriting, claim evaluation or processing, medical or disability assessment and management, or treatment, payment, and operations related activities (the "Permitted Activities"). The Company may possess and further disclose Personal Information obtained from me, Third Parties, or developed by the Company to other Third Parties, claim or medical management organizations, investigative firms, agents, employees, consultants, and others who have a legitimate business interest in obtaining the minimum necessary Personal Information in connection with the Permitted Activities. If any provision of this authorization is or becomes invalid or unenforceable pursuant to applicable Federal or State laws, it shall be ineffective only to the extent of such invalidity or unenforceability, and the remaining provisions of this authorization shall not be affected. This authorization is valid for the lesser of: the period that my coverage from the Company remains in effect or; if this authorization is given in connection with the Company's consideration of a claim for benefits, for the duration of the Company's consideration of that claim. I have the right to revoke this authorization, in writing, at any time or to refuse to sign this authorization. I acknowledge that if I do so, that revocation may adversely affect the completion of the Permitted Activities, including the denial of a claim for benefits. Any written revocation of this authorization shall become effective upon receipt by the Company, but shall not apply retroactively as to Personal Information that has been previously disclosed, obtained, or used in accordance with this authorization. A photocopy of this form is as valid as the original. A copy of this authorization will be provided to me or my authorized representative upon request.

Name (last, first, middle)	
Telephone No.	Email Address
Signature	Date

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FRAUD NOTICE

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FOR YOUR PROTECTION, THE LAWS OF SOME STATES MAY REQUIRE US TO FURNISH YOU WITH THE FOLLOWING NOTICE: 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. Please see below for special notices required by state law for residents.

AL	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.
AK	Any 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.
AZ	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.
DE, ID, IN	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.
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.
FL	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 of the third degree.
KS	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 may be guilty of a crime and subject to fines and confinement in prison as determined by a court of law.
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, TN	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, and denial of insurance benefits.
MD, RI, TX	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.
MN	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
NH	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, as provided in RSA 638:20.
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 the 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	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	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 may be guilty of a crime and subject to fines and confinement in prison.
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.
VT	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.
VA,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.

SIGN AND DATE BELOW (I have read and understand the Fraud Warning that applies to my state of residence.)

Name (last, first, middle)	Telephone No.
Signature	Date