USAble Life℠

INSURED'S STATEMENT | For Stroke

Send claim form/related documents to:
- **Attn:** Claims Department
  USAble Life
  P.O. Box 1650
  Little Rock, AR 72203-1650
- **Email:** claims@usablelife.com
- **Fax:** 501-235-8416

Thank you for selecting coverage from USAble Life.
- Included are the necessary forms to file a claim.
- Complete each form, with all the information sections that apply to your claim, and sign.
- For more space, attach additional pages with required information.
- For clarity, the Insured is referred to as "you", "your" and "patient" on this form.
- Special note on timing: A claim must be received within 90 days of the event, loss or date of service (unless state law indicates otherwise).

You may reach us with any questions at 800-370-5856, Monday-Friday, 8:00 a.m. to 5:00 p.m. CT.

Personal Information

List your personal information.

Insured patient's name | Social Security Number | Birth date

Best phone number | Email address

Home address

City | State | Zip

Employer name

Your Condition

Tell us about your condition and reason for claim.

How long have you been under a physician's care?

What date did you first consult a physician for this condition? | When did symptoms first appear?

Was this the first stroke that you have had?

What neurological deficits have persisted for greater than three (3) months?

Were you tested using the Modified Rankin Scale? ❍ Yes ❍ No
If Yes, what were the dates and by whom?

For which conditions have you been treated for within the last 5 years?
Provide condition, diagnosis and diagnosis date.

Physicians' Information

Provide contact information for first doctor seen.

Physician name | Practice name | Specialty

Office address

City | State | Zip | Phone

Provide names and addresses of all doctors seen for this condition.

Physician name | Office address

City | State | Zip

Provide names and addresses of all doctors seen for any condition in the past five years.

Physician name | Office address

City | State | Zip

Condition

Signature

Sign and date this form.

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

Patient's name | Best phone number

Patient's signature | Date

⚠ **Fraud Warning:** Except as noted in the separate Fraud 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.

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ATTENDING PHYSICIAN'S STATEMENT | For Stroke

Send claim form/related documents to:
- **Attn:** Claims Department
  USAble Life
  P.O. Box 1650
  Little Rock, AR 72203-1650
- **Email:** claims@usablelife.com
- **Fax:** 501-235-8416

Thank you for selecting coverage from USAble Life.
- Please have your physician complete this form, sign and date.

You may reach us with any questions at 800-370-5856, Monday-Friday, 8:00 a.m. to 5:00 p.m. CT.

Attn: Physician
- The named insured below has filed a claim for benefits due to stroke.
- The insured has given us authorization (see attached) to obtain information needed to assess the claim.
- Please answer the questions below and return to us with the supporting documentation.

Patient Information

Tell us about your patient's condition.

Patient's full name • | Social Security Number • | Birth date •

How long has the patient been under your care?
•

What date were you first consulted for this condition?
•

When did symptoms first appear for this condition?
•

When was the patient first advised of their stroke?
•

Was this the first stroke that the patient has had?
•

What clinical symptoms were present at the time of the evaluation?
•

Was a CT scan performed? ❍ Yes ❍ No
If Yes, what were the results?
•

Was an MRI performed? ❍ Yes ❍ No
If Yes, what were the results?
•

What other studies were done to confirm the diagnosis of stroke?
•

Has the insured previous evidence of hypertension, cardiac septum defects, transient ischemic attacks, hemophilia, valvular disorders of the heart, pulmonary embolus, embolism of any major vessel, aneurysms of the intracranial blood vessels, diabetes mellitus, arteriosclerosis, disturbances of fat metabolism, arteriovenous malformations, angina pectoris, coronary heart disease, chest pain on exertion, abnormal EKGs, hyperlipidemia or atrial fibrillation? ❍ Yes ❍ No
If Yes, please give dates of consultation(s) and diagnosis(es).
•

What neurological deficits have persisted for greater than three (3) months?
•

Was the patient tested using the Modified Rankin Scale? ❍ Yes ❍ No
If Yes, what were the dates and results?
•

For which conditions have you treated this patient in the last 5 years?
Provide diagnosis and diagnosis date.
•

Physicians' Information

Provide primary care physician information.

Physician name • | Practice name • | Specialty •

Office address
•

City • | State • | Zip • | Phone •

Provide neurologist information (if applicable).

Physician name • | Practice name • | Specialty •

Office address
•

City • | State • | Zip • | Phone •

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ATTENDING PHYSICIAN'S STATEMENT | For Stroke

Physicians' Information (continued)

Was the patient referred to you by another physician? ❍ Yes ❍ No
If Yes, please provide contact information.

Referring physician name | Practice name | Specialty

Office address

City | State | Zip | Phone

Has the patient been hospitalized for this condition? ❍ Yes ❍ No
If Yes, please provide contact information.

Hospital name | Specialty

Hospital address

City | State | Zip

Supporting Documentation

Include supporting documentation.

Office notes from the past 5 years have been attached? ❍ Yes ❍ No
If No, where could these records be obtained?

Hospital and/or surgical notes have been attached? ❍ Yes ❍ No
If No, where could these records be obtained?

CT Scan, MRI report, Modified Rankin Scale assessment have been attached? ❍ Yes ❍ No
If No, where could these records be obtained?

Physician's Signature

Sign and date this form.

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

Physician's name | Phone

Physician's signature | Date

Physician's address

City | State | Zip

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AUTHORIZATION | To Disclose, Obtain and Use Personal Information

Read and sign below.

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.

Signature

Sign and date this form.

I have executed this authorization intending that it will be effective on and after:

Date

•

Signature

•

Printed name

•

Return original with your claim and retain a copy of this authorization and claim form for your records.

USABLE LIFE℠ | FRAUD NOTICE

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.

AL Residents Only: 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 Residents Only: 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 Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA Residents Only: 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 Residents Only: 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, OK Residents Only: 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 Residents Only: 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 Residents Only: 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 Residents Only: 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 Residents Only: 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 and TN Residents Only: 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 Residents Only: 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 Residents Only: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

OH Residents Only: 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.

OR Residents Only: 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 Residents Only: 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 Resident Only: 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 and WA Residents Only: 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.

LAST NAME, FIRST NAME, MI *(PRINTED)*	SIGNATURE	TODAY'S DATE