USAble Life

ACCIDENT BENEFITS CLAIM | PROCESS

FOR QUESTIONS, CONTACT CUSTOMER SERVICE AT 1-800-370-5856, MONDAY THROUGH FRIDAY, 8:00 AM TO 5:00 PM CST.

WHERE TO SUBMIT YOUR CLAIM:
Attention: Claims Department
Mail: P.O. Box 1650 | Little Rock | AR | 72203
Email: claims@usablelife.com | **Fax:** 501-235-8416

IMPORTANT NOTE

Please remember that claims must be received within 90 days (unless state law indicates otherwise) of the loss or date of service. Losses resulting from motor vehicle accidents or homicide require a copy of the investigating officer's report.

OBTAIN THE REQUIRED DOCUMENTS

To process your accident claim for **MEDICAL EXPENSES**, please submit the following documents:

You complete:
- ☐ **INSURED'S STATEMENT**
- ☐ **AUTHORIZATION TO RELEASE**
- ☐ **FRAUD NOTICE**

Please have your physician complete the **ATTENDING PHYSICIAN'S STATEMENT - MEDICAL EXPENSES, Emergency Room report,** or **office visit notes,** along with **itemized bills** from all medical providers.

To process your accident claim for **DISABILITY BENEFITS (ACCIDENT/SICKNESS DISABILITY RIDER – PRIMARY INSURED ONLY)**, please submit the following documents:

You complete:
- ☐ **INSURED'S STATEMENT**
- ☐ **AUTHORIZATION TO RELEASE**
- ☐ **FRAUD NOTICE**

Your physician completes:
- ☐ **ATTENDING PHYSICIAN'S STATEMENT - DISABILITY CLAIM**

Your employer completes:
- ☐ **EMPLOYER'S STATEMENT**

To process your accident claim for **ACCIDENTAL DEATH**, please submit the following documents:

You complete:
- ☐ **INSURED'S STATEMENT**
- ☐ **AUTHORIZATION TO RELEASE**
- ☐ **FRAUD NOTICE**
- ☐ **ACCIDENTAL DEATH CLAIM SECTION**

If the benefit amount is over $50,000, you will need to submit an original Death Certificate (copies are not accepted). If a police report is available, include a copy of the report with your claim. *Additional information may be requested.*

To process your accident claim for **WELLNESS BENEFIT**, please submit a **CLAIM FORM - WELLNESS BENEFIT**. The claim form can be downloaded from yourdocumentcenter.com.

SUBMIT YOUR CLAIM FORM & DOCUMENTS

To submit your claim via email, please scan your documents and **email to claims@usablelife.com**.

You can also send your claim via **fax to 501-235-8416**, or by **mail to ATTN: Claims Department, P.O. Box 1650, Little Rock, AR 72203**.

USAble Life

CLAIM FORM | For Accident Recovery Benefits

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 *(if faxing, original claim form documents must also be mailed to us)*

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

Gender ❍ Male ❍ Female | Email address

Home address

City | State | Zip | Best phone number

Employer name

Patient Information

Only complete if a dependent was the hospital patient.

Name of person injured or suffering a loss | Social Security Number | Birth date

Gender ❍ Male ❍ Female | Relation to insured ❍ Spouse ❍ Child ❍ Other (specify):

If child, living in your household? ❍ Yes ❍ No | *If no,* specify with whom the child resides:

If child, full-time student? ❍ Yes ❍ No | *If yes,* provide school name:

Accidental Injury or Loss Description

Tell us how you or your dependent were injured or suffered a loss due to an accident.

Describe injury or loss | Where did it happen?

How did it happen? | When did it occur? (date and time of day)

First treated by ❍ Hospital ❍ Physician | Name of hospital or physician:

Address

City | State | Zip | Phone

Claim Information

Complete one of the following 3 sections.

1) Medical Expenses Claim

Itemized bills from hospital and all medical providers are required for a medical expenses claim.

2) Disability Benefits Claim

Employer must complete <u>and</u> sign this section if accident and sickness rider applies for disability benefits.

Employer name | Tax ID number | Group policy number

Address

City | State | Zip

Employee Social Security Number | Date of hire

Date of last day worked | Hours | Date returned to work ❍ Full-time ❍ Part-time

Hours per week employee regularly works | Employee regularly works weekends? ❍ Yes ❍ No

Has a workers compensation claim been filed or expected to be filed for this disability? ❍ Yes ❍ No

Are the employee's disability premiums sheltered under a Section 125 Cafeteria Plan (withheld before taxes)? ❍ Yes ❍ No

Employer signature | Title | Date

Phone number | Fax number

3) Accidental Death

Only complete this section if loss of life occurred due to accident. You are required to obtain and include an Official Death Certificate.

Official Death Certificate is required. If death was due to suicide, homicide or accidental means, a copy of the investigating officer's report is also required. By furnishing this form and investigating the claim, USAble Life shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

Name of deceased • | Age at death • | Date of death •

Residence at time of death (address) •

City • | State • | Zip •

Location of death • | Cause of death •

Death due to ❍ Accidental bodily injury ❍ Homicide ❍ Other (please provide details and date): •

Was there an autopsy, inquest or post mortem examination ❍ Yes ❍ No *If yes,* by whom (explain): •

Relation to employee ❍ Spouse ❍ Child

If spouse, was the deceased divorced or legally separated from you at the time of death? ❍ Yes ❍ No

If child, was the deceased married at the time of death? ❍ Yes ❍ No

Signature

Sign and date this form.

I certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Employee's name •

Employee's signature • | Date •

Address •

City • | State • | Zip •

Employee's Social Security Number • | Best phone number •

⚠ **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.

USAble Life

ATTENDING PHYSICIAN'S STATEMENT | For Accident and Injury

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 an accident or injury.
- 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 •

Nature of injury (include ICD Codes) •

When did it occur? (date and time of day) •

Date patient first consulted you? •

Has the patient ever had same or similar condition? ❍ Yes ❍ No
If Yes, when? •

If loss of limb, was it through or above wrist or ankle joint? ❍ Yes ❍ No

If loss of sight, is it permanent or irrecoverable? ❍ Yes ❍ No

Was the loss of sight or dismemberment solely due to accidental bodily injury without other causes? ❍ Yes ❍ No
If Yes, on what date did it become so? If No, please explain. •

If loss due to burn, specify degree and size:
❍ First Degree ❍ Second Degree *Percentage of body surface burned:* • ❍ Third Degree *Percentage of body surface burned:* •

If loss due to dislocation, complete separation? ❍ Yes ❍ No
If Yes, ❍ Open reduction ❍ Closed reduction

If loss due to fracture: ❍ Simple ❍ Compound ❍ Open reduction ❍ Closed reduction

If loss due to laceration:
Total length: ❍ Less than 5.0 cm ❍ 5.08 – 15.24 cm ❍ Greater than 15.24 cm
Type of repair: ❍ Stitches ❍ Staples ❍ Glue ❍ Other

Were any surgical procedures involved? ❍ Yes ❍ No
If Yes, please describe and provide date performed. •

Physician's Information & Signature

Provide your information, sign and date.

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 • | Degree • | Phone •

Physician's signature • | Date •

Physician's address •

City • | State • | Zip • | Fax •

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USAble Life

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