



ACCIDENT PLUS + INSURANCE INSTRUCTIONS FOR FILING CLAIMS

Dear Policyholder:

Thank you for choosing US Able Life to provide your accident coverage. We have included these instructions and the necessary form to assist you in the event you need to file a claim. **Please remember that claims must be received within 90 days of the loss, and that your claim form must be completed by you and the attending physician. We cannot accept incomplete claims.**

DISMEMBERMENT, FRACTURE, DISLOCATION AND OTHER INJURY CLAIMS

1. Complete and have the injured person sign the Insured's Statement (parent or guardian should sign if minor) on the Statement of Claim, Statement of Claim, Accident Plus + Insurance claim Form, CL-AP.
2. Answer **ALL** questions, or state "not applicable." Incomplete forms will be returned.
3. Obtain the Attending Physician's Statement on the reverse side of Form CL-AP. Be sure **ALL** questions are answered **AND** the form is signed. If services were provided by a hospital emergency/outpatient department, we will accept a copy of the record of treatment.
4. Attach **ITEMIZED** bills for all treatment received, including emergency room, physician's office, hospital inpatient and ambulance. We are sorry, but we cannot accept billing summaries or Explanations of Benefits from other insurance claims.
5. If the injury was the result of a motor vehicle accident, please submit a complete report of the accident from the investigating law enforcement agency.

ACCIDENTAL DEATH CLAIMS

1. The policyholder or next of kin should complete the Insured's Statement on the Statement of Claim, Accident Plus + Insurance Claim Form CL-AP.
2. Obtain the statement of the physician who examined the deceased at death on the reverse side of Form CL-AP. Be sure **ALL** questions are answered and the form is signed.
3. Attach a **CERTIFIED** copy of the death certificate. This can be obtained from the funeral home making the arrangements.
4. Attach a police report from the investigating enforcement agency if the death was due to suicide, homicide, or motor vehicle accident.

Mail or Fax Claim Forms and Bills to:

Claims Department
US Able Life
PO Box 1650, Little Rock, AR 72203

For Questions or Assistance Call:

Claim Department
US Able Life
(800) 370-5856
8 a.m. to 4:30 p.m. Central Time

***FRAUD WARNING:** Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.*



Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856
Fax (501) 235-8416

Statement of Claim

Accident Plus + Insurance

For H.O. Use Only
Eff _____
PTD _____
Benefits _____

- How To File Your Claim:**
1. Complete Claimant Statement.
 2. Have your doctor complete Attending Physician Statement.
 3. Attach ITEMIZED bills for services.

Important: Read Carefully

This form should be completed by the attending physician and by the claimant upon the death or loss by an insured employee or dependent and should be forwarded to US Able Life. It will be necessary to furnish a copy of the investigating officer's report for loss due to suicide, homicide or motor vehicle accident. A certified copy of the death certificate is also required for loss of life claims. By furnishing this form and investigating this claim, US Able Life shall not be held to admit the validity of any claim or to waive or breach any condition of the policy.

INSURED'S STATEMENT

Name of Insured		Policy Number	Social Security Number
Home Address (Number and Street)		(City, State)	(Zip)
Home Address (Number and Street)		(City, State)	(Zip)
Name of Person Suffering Injury		Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to Insured			
Patient's Social Security Number	Home Address (Number and Street)		
Describe Injury		Claimant Is: <input type="checkbox"/> Beneficiary <input type="checkbox"/> Spouse <input type="checkbox"/> Insured <input type="checkbox"/> Parent	
Where Injury Happened (Street, City, State)	When Injury Happened (Date and Time)		Date of Death (if applicable)
How Injury Happened			

I hereby authorize any physician or practitioner of the healing arts who has examined or treated me, and all hospitals, clinics or medically related facilities, insurance companies, health maintenance organizations, Medical Information Bureau, government entity (federal, state or local) or other organization, institution or person, that has any information, records or knowledge of me or my health, past or present, to furnish such information to US Able Life (or its representatives) and to permit them to examine and copy such information. I understand that US Able Life may disclose the information to the Medical Information Bureau, or reinsurers, or agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claims processing with the company. A copy of this authorization, or the original, shall be valid for the duration of the claim from the date signed. I acknowledge that I have a right to a copy of this authorization upon request.

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Date: _____ **Signature of Patient** _____
(Parent/Guardian if Minor)

Please Have Your Attending Physician Complete Page2/Reverse Side.

ATTENDING PHYSICIAN'S STATEMENT (APS)**Please Answer All Applicable Questions.**

Name of Patient		Date of Birth
Home Address (Number and Street)	(City, State)	(Zip)
Nature of Injury (Include ICD Codes)		When Did It Occur?
If loss of limb, was it through or above wrist or ankle joint? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If loss of sight, is it entire and irrecoverable? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, on what date did it become so? Date		
Was the loss of sight or dismemberment solely due to accidental bodily injury without other causes? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain:		
Were any surgical procedures involved? <input type="checkbox"/> Yes <input type="checkbox"/> No Please Describe:		Date Performed
Date Patient First Consulted You _____ If hospitalized, date _____ <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Hospital Name _____ Address _____ City, State, ZIP _____		How long was or will patient be unable to work? (Principal Insured ONLY) From _____ Through _____ Can return to work on _____
Has Patient Ever Had Same Or Similar Condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, Date _____ Describe:		Describe any circumstances causing disability to be prolonged:

The following questions apply to Loss of Life ONLY.

Date of Death	Immediate Cause of Death	Place of Death (If in hospital or institution, give name)
Was Death Due To <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Accidental Bodily Injury		
Were there any contributing causes of death? Give the dates and duration of each as closely as you can.		
Was there an autopsy, inquest, or post mortem examination? By whom?		

DOCTOR'S SIGNATURE NEEDED FOR ACCIDENT OR LOSS OF LIFE.

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.		
Physician's Signature		Date
Physician's Name		Degree
Address		Telephone
City	State	Zip

CLAIMANT: Please complete Page 1/Reverse side and attach your ITEMIZED bill for services.

FRAUD NOTICE

For your protection, the laws of some states may require us to furnish you with the following notice:

Except as otherwise noted below, it is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Arizona

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

California

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.

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 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.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey

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

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.

Retain for your records.