



Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone: (501) 378-5856 (800) 370-5856

Accident Benefits Claim Form & Instruction Packet

Dear Policyholder:

Thank you for choosing US Able Life to provide your accident coverage. We have included these instructions and the necessary forms 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 or date of service. You and your attending physician must complete the claim forms for Medical Expenses, Disability and Accidental Death. Disability claims also require your employer's statement. An Authorization for Release of Medical Records must be completed and returned along with the completed claim form. If faxing a claim, the original must also be mailed.

IMPORTANT NOTE: Losses resulting from motor vehicle accidents or homicide require a copy of the investigating officer's report. Incomplete claims cannot be processed and will be returned to you.

CLAIMS FOR MEDICAL EXPENSES

1. Complete the Insured's Statement on the back of this page.
2. Obtain the Attending Physician's Statement - Medical Expenses found in this packet.
3. Obtain ITEMIZED bills from all medical providers.
4. Complete the Authorization for Release of Medical Records.
5. Mail the completed forms and bills to US Able Life.

DISABILITY (Accident/Sickness Disability Rider - Principal Insured Only)

1. Complete the Insured's Statement on the back of this page.
2. Obtain the Attending Physician's Statement - Disability Rider found in this packet.
3. Obtain the Employer's Statement.
4. Complete the Authorization for Release of Medical Records.
5. Mail the completed forms to US Able Life.

ACCIDENTAL DEATH

1. Complete the Insured's Statement on the back of this page.
2. Obtain the Attending Physician's Statement - Accidental Death found in this packet.
3. Obtain a CERTIFIED DEATH CERTIFICATE (available from funeral home).
4. Complete the Authorization for Release of Medical Records.
5. Mail the completed forms and death certificate to US Able Life.

WELLNESS BENEFIT (if applicable to your policy)

1. Please mail us an ITEMIZED bill for the covered test or service. Payment will be mailed to the address on the bill. Please make sure this address is correct. (Do not rely on your physician or hospital to file your claim.)
2. You do NOT need a claim form or an Authorization for Release of Medical Records to collect reimbursement for these benefits BUT the following information must be submitted:
 - * Insured's Name and Social Security Number
 - * Policy Number (very important)
 - * Patient's Name, Date of Birth, and Social Security Number
 - * Date of Service
 - * You may write the above on the itemized bill for submission

Mail Claim Forms & Bills to:

US Able Life
ATTENTION: CLAIMS DEPARTMENT
PO Box 1650, Little Rock, AR 72203-1650
1-800-648-0271 or (501) 375-7200

For Questions or Assistance Call:

US Able Life
1-800-370-5856 or (501) 378-5856
8:00 a.m. - 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.*

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.



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Accident Benefits Statement of Claim

INSURED'S STATEMENT			
Name of Insured		Social Security #	Age
		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Home Address (Number and Street)		(City, State)	(Zip)
		Daytime Telephone ()	
Name of Person Suffering Loss		Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Relation to Insured	
Home Address (Number and Street)		(City, State)	(Zip)
Loss Suffered			
Name of Claimant		Social Security #	Date of Birth
Relation to Insured		Claimant is <input type="checkbox"/> Beneficiary <input type="checkbox"/> Insured <input type="checkbox"/> Other	
Home Address (Number and Street)		(City, State)	(Zip)
		Daytime Telephone ()	
Where Injury Happened (Street, City, State)	When Injury Happened (Date and Time)		Date of Death (if applicable)
How Injury Happened			
Names and addresses of all physicians who attended or prescribed for the insured in the past 5 years			
<u>Physician</u>	<u>Address</u>	<u>Dates of Attendance</u>	<u>Disease or Condition</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Names and addresses of all hospitals where insured was treated within 5 years preceding accident.			
<u>Hospital</u>	<u>City/State</u>	<u>Dates of Treatment</u>	<u>Disease or Condition</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
<p>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.</p> <p>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.</p>			
Date: _____		Signature of Claimant: _____	

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CLAIMANT: PLEASE REMEMBER

1. To complete ALL questions and sign this form.
2. To obtain the Attending Physician's Statement(s).
3. To obtain a copy of the investigating officer's report if loss due to motor vehicle accident or homicide.
4. To obtain the Employer's Statement (Disability Riders and Principal Insured Only).
5. To attach ITEMIZED bills.
6. To complete the Authorization for Release of Medical Records.

ATTENDING PHYSICIAN'S STATEMENT - ACCIDENTAL DEATH

Please complete if claim is for loss of life.

Name of Deceased		Age at Death
Residence at Time of Death (Number and Street)		(City, State) (Zip)
Date of Death	Place (if in hospital or institution, give name)	
Cause of Death (Including ICD Codes)		
Was Death Due To: <input type="checkbox"/> Accidental Bodily Injury <input type="checkbox"/> Homicide <input type="checkbox"/> Other (Give details in Remarks section)		
Give Details and Date		
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?		
Remarks: _____ _____ _____		

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 ()	Fax ()
City	State	Zip

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CLAIMANT: PLEASE REMEMBER

1. To complete ALL questions and sign Insured's Statement.
2. To obtain the investigating officer's report if loss due to motor vehicle accident or homicide.
3. To attach a CERTIFIED copy of the death certificate.