



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

HOSPITAL CONFINEMENT INDEMNITY CLAIM FORM & INSTRUCTION PACKET

Dear Policyholder:

Thank you for choosing US Able Life to provide your Hospital Confinement Indemnity 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 confinement. You and your attending physician must complete the claim form. 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 Employee/Patient's Statement on page 2.
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. Fax or Mail the completed forms and ITEMIZED bills to US Able Life.

WELLNESS BENEFIT (If applicable to your policy.)

1. Please fax or 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

For Questions or Assistance or to Submit Claim Forms and Itemized Bills:

By Mail:
US Able Life
Attention: Claims Department
PO Box 1650, Little Rock AR 72203-1650
Telephone: (800) 370-5856
8:00 a.m. – 4:30 p.m. Central Time

By Fax:
US Able Life
Attention: Claims Department
(501) 235-8416

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.



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Statement of Claim Hospital Confinement Indemnity

For H.O. Use Only	
Eff.	_____
PTD	_____
Plan Code	_____
Issue Age	_____

- How To File Your Claim:**
1. Please make sure all questions in the Insured Employee/Patient's Statement section are completed in full.
 2. Authorization must be signed and currently dated.
 3. Physician Statement on page 3 must be completed.

Type of Claim: Inpatient Hospital Accident/Injury

Insured Employee/Patient's Statement

Employee's Name (Last, First, MI)		Employee's Birthdate	Employee's Social Security No.
Employee's Address (Street, City, State, Zip)		Employee's Daytime Telephone No.	
Employer Name	Group Policy #	Current Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> On Leave <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed	
Employer Address (Street, City, State, Zip)		If on leave, retired or not employed: Date Last Worked Mo Day Year	
Patient's Name (Last, First MI)		Patient's Birthdate	Patient's Social Security No.
Patient is:		Specify Relationship	
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:			
If Patient is your child, is he living in your household? <input type="checkbox"/> Yes <input type="checkbox"/> No		(If no, specify with whom the child resides.)	
If patient is your child, is he a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		School Name	
Nature of Illness or Injury		Date of 1st Treatment	
Accident Date	Time (include a.m. or p.m.)	Place	
How did the accident happen?			
Has the patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, indicate date and describe	
Has patient had other medical attention in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Describe conditions, name doctors consulted, hospitals where treated, their addresses, and give dates seen. (Attach separate sheet if needed.) _____ _____			

Authorization to Obtain Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to US Able Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original. 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 patient is a minor)

**Please have your Attending Physician complete Page 3
and attach itemized copies of your bills.**

ATTENDING PHYSICIAN'S STATEMENT – MEDICAL EXPENSES**Please Answer All Applicable Questions**

Name of Patient		Date of Birth
Nature of Injury or illness (Include ICD Codes)		When Did it Occur
Date Patient First Consulted You	Date symptoms first appeared	Has Patient Ever Had Same of Similar Condition? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, When: _____
If hospitalized, date _____ <input type="checkbox"/> In Patient <input type="checkbox"/> Outpatient		
Hospital Name: _____		
City, State _____		
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 permanent or irrecoverable? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, on what date did it become so? Date: _____ If No, what percentage of sight remains? _____
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
If loss due to burn, specify degree and size: <input type="checkbox"/> First Degree <input type="checkbox"/> Second Degree _____ Percentage of Body Surface Burned <input type="checkbox"/> Third Degree _____ Square Inches of Body Surface Burned		
If loss due to dislocation, complete separation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Open Reduction <input type="checkbox"/> Closed Reduction		
If loss due to fracture: <input type="checkbox"/> Simple <input type="checkbox"/> Compound <input type="checkbox"/> Open Reduction <input type="checkbox"/> Closed Reduction		
If loss due to Laceration: Total Length: <input type="checkbox"/> Less than 5.08 cm <input type="checkbox"/> 5.08 – 15.24 cm <input type="checkbox"/> Greater than 15.24 cm Type of Repair: <input type="checkbox"/> Stitches <input type="checkbox"/> Glue <input type="checkbox"/> Staples <input type="checkbox"/> Other		
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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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.