Accident Claim Filing Instructions

Underwritten by: ManhattanLife Insurance Company
Administered by: Bay Bridge Administrators, LLC

Page 1 – Insured's Statement of Claim:

Must be completed each time you file a claim. Be sure to answer every question. If filing a claim due to accident/injury where a police report was filed, a copy of the police report must be included with claim.

Page 2 – Authorization

Claimant or Authorized Representative must sign and date Authorization to allow physicians to release medical records to Bay Bridge Administrators, LLC

Pages 3 & 4 – Pre-existing Review Form

If claim is being filed within the first year of the policy, please complete this page with all physicians seen or medications taken in the past 24 months.

If provider fax numbers are known, please provide them in order to expedite this process. Please make certain authorization is signed and dated.

Page 5 - Employer's Statement

If you are filing for total disability benefits, this form must be completed by your Employer representative.

Pages 6 & 7 - Physician's Statement

To be completed by your treating Physician. If treated in an emergency room, the admit and discharge summary may be submitted in lieu of this form.

Please attach itemized billings from your providers that include dates of service, diagnosis and procedure codes, and corresponding Explanation of Benefits statement from the primary health insurance.

ALL REQUIRED PORTIONS OF THIS CLAIM FORM MUST BE COMPLETED TO AVOID UNNECESSARY DELAY IN THE PROCESSING OF YOUR REQUEST FOR BENEFITS.

Return fully completed claim form and supporting documentation via:

Mail	E-mail	Portal	Fax
Bay Bridge Administrators, LLC PO Box 161690 Austin, TX 78716	claims@bbadmin.com	portal.bbadmin.com	512-275-9350

For questions call: 800-845-7519

Claim Form for Accident	Underwritten by: Manhattan Life Insurance Company Administered by: Bay Bridge Administrators, LLC PO Box 161690 Austin TX 78716 800-845-7519

INSURED'S STATEMENT OF CLAIM

Name of Insured:	Insured's Date of Birth:	Policy Number:
Street Address:		Phone Number (area code first):
Name of Claimant:	Claimant's Date of Birth:	Relationship to Insured:

Illness or Injury for which claim is being made:	Date of Accident or date Illness was first diagnosed:	Date you were first treated for your Illness or Injury:

Describe the onset and nature of your Illness or Injury:

Have you ever had the same or a similar condition in the past? ◯ Yes ◉ No Date _____	Treated by: Hospital: _____ Name Address Doctor: _____ Name Address
Have you ever had the same or a similar condition in the past? ◯ Yes ◉ No Date _____	Treated by: Hospital: _____ Name Address Doctor: _____ Name Address

Only complete the following portion if covered by and applying for Disability benefits under the optional rider on the Accident Policy

6. Between what dates were you totally and continuously disabled? From _____ to _____

7. Between what dates were you partially disabled? From_____ to _____

8. If still disabled, when do expect to resume full duties?_____

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.

Signature of Insured_____

Date _____

The above Statements are true to the best of my knowledge and belief

AUTHORIZATION
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that my protected health information will be used for the purpose of evaluating my claim. I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. Only this information may be used and/or disclosed pursuant to this authorization.
2. I authorize all health care professionals, pharmacies and pharmacy benefit managers to disclose my protected health information.
3. I authorize only designated staff of Bay Bridge Administrators, LLC. to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
4. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
5. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Bay Bridge Administrators, LLC. This revocation shall become effective on the date it is received by Bay Bridge Administrators, LLC. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.
6. This Authorization is valid for twelve (12) months from the date of execution hereof.

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS AUTHORIZATION AND AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS CONTEMPLATED HEREIN.

Signature	Print Name	Date

I have legal authority* under the laws of the State of _____ to make health care decisions on behalf of _____, the individual to whom the use and/or disclosure of protected health information above applies, and execute this Authorization in my capacity as Authorized Representative thereof.

Name of Authorized Representative	Relationship to Applicant	Date

Parent or Guardian*A copy of the legal authority document must be on file with Bay Bridge Administrators, LLC

If claim is being filed during the first year of the policy, please complete the following.

Please list all physicians that treated the patient within the last two years:

Physician's Name: ______________________________

Address: ______________________________

Telephone Number: ______________ Fax Number: ______________

Approximate Date Consulted: ______________ Diagnosis: ______________

Physician's Name: ______________________________

Address: ______________________________

Telephone Number: ______________ Fax Number: ______________

Approximate Date Consulted: ______________ Diagnosis: ______________

Physician's Name: ______________________________

Address: ______________________________

Telephone Number: ______________ Fax Number: ______________

Approximate Date Consulted: ______________ Diagnosis: ______________

Physician's Name: ______________________________

Address: ______________________________

Telephone Number: ______________ Fax Number: ______________

Approximate Date Consulted: ______________ Diagnosis: ______________

Physician's Name: ______________________________

Address: ______________________________

Telephone Number: ______________ Fax Number: ______________

Approximate Date Consulted: ______________ Diagnosis: ______________

Please list all prescribed medications now being taken by patient:

Name of Medication	Prescribing Doctor	Date First Prescribed

Any person who, with 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 subject to prosecution and punishment for insurance fraud.

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Employer's Statement

To be completed by Employer	
Employee's Name:	
Employee's SSN:	Date of Birth:
Date last worked or placed on light duty status: _____ Reason for stopping work: _____ Is Employee's job being held open? ☐ Yes ☐ No	
Has Employee returned to regular work status? ☐ Yes ☐ No If yes, full-time date: _____ Part-time date: _____	
Name and Address of Employer:	
E-mail Address:	
Phone Number:	Fax Number:
_____ **Printed Name and Title** _____ _____ **Employer Signature** **Date**	

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Physician's Statement

To be completed by the Medical Provider		
Patient Name:		Date of Birth:
Diagnosis:	ICD-10 Code:	Date of Diagnosis:

Date Disability Commenced: _____

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No

Dates of Treatment:

Date of first visit: _____ Date of last visit: _____

Frequency of Treatment: ☐ Weekly ☐ Monthly ☐ Other: _____

Has patient been hospital confined for this condition? ☐ Yes ☐ No
If yes, please list name of hospital and dates:

Has this patient been treated for this same or similar condition in the past prior to this occurrence?
☐ Yes ☐ No

If yes, diagnosis: _____

Dates of Treatment: _____

Name and address of Referring Physician:

Nature of Treatment – please describe course of treatment:

Progress – prognosis with reasonable estimate of return to work date:

Limitations (what the patient CANNOT do):	
Physical Impairment *(as defined in Federal Dictionary of Occupational Titles): ☐ **Class I – No limitation of functional capacity; capable of heavy work *no restrictions (0-10%)** ☐ **Class 2 – Medium manual activity *(15-30%)** ☐ **Class 3 – Slight limitation of functional capacity; capable of light work *(35-55%)** ☐ **Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)** ☐ **Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)**	
Remarks:	
Provider's Name and Mailing Address:	
Provider's Phone Number:	Provider's Fax Number:
Physician's Name and Mailing Address:	
Physician's Phone Number:	Physician's Fax Number:
_____ **Physician's Signature**	_____ **Date**

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FRAUD WARNING

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: 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.

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 or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maine, Tennessee and Washington: 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 or a denial of insurance benefits.

Maryland: 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.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Vermont: 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.

Virginia: 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 may have violated the state law.

Pennsylvania and all other states: 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.

BAY BRIDGE ADMINISTRATORS

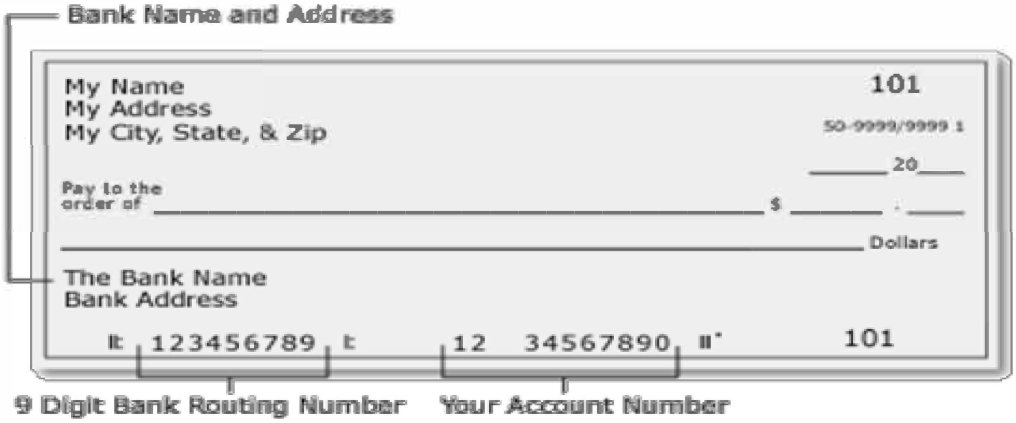
We are pleased to offer electronic ACH (Automated Clearing House) payments for your supplemental coverage benefit payments. ACH payments provide an alternative to paper checks, affording you the following advantages:

- Better cash management forecasting - accelerated funds availability – certainty of delivery
- Establishment of excellent payment and credit records
- Being part of "Going Green" by reducing paper

Enrolling means payment will deposit into your bank account, eliminating use of paper checks and mail delays. We will continue to send you the corresponding Explanation of Benefits via regular mail.

Frequently Asked Questions

How do I get started? Complete and sign the Direct Deposit Authorization Agreement Form. Below reflects where you find the bank routing/bank account numbers that need to be included.



What is the process of enrolling in ACH? Once we receive your completed form, the form is sent to the team that builds the ACH set up.

How long does the ACH enrollment process take? It could take up to 3 business days for the ACH to become effective.

What needs to happen if we change account numbers or financial institutions? If you want to change your ACH electronic authorization, please complete another Direct Deposit Authorization Agreement Form and submit it. Include a note on the form indicating this is for a change in information.

How long does the ACH authorization remain in effect? Your authorization will remain in effect until we receive notification form you that you prefer receiving a check in the mail.

Indemnity Policy Benefit Payment
Direct Deposit Authorization Agreement

First Name | MI | Last Name | SSN

Street Address | City | State | ZIP Code

Phone | Email

Bank Name | Account No. | Routing/Transit No. | Account type: ○ Checking ○ Savings

Bank Address: Street, City, State, Zip | Name(s) on Bank Account

Please Attach Voided Check Here

I (we) hereby authorize Bay Bridge Administrators, LLC hereinafter call "Company" to initiate credit entries to my (our) account indicated above at the depository financial institution named above, hereinafter called "Bank," and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

This authorization is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Bank a reasonable opportunity to act on it.

Authorized Signature | Date

(Signature must match signature card on account)

Bay Bridge Administrators, LLC.
P.O. Box 161690, Austin, TX 78716
Phone: (800) 845-7519 Fax: (512) 275-9350
Email: underwriting@bbadmin.com
Website: www.bbadmin.com

BAY BRIDGE ADMINISTRATORS