Bay Bridge Administrators, L.LC.
P O Box 161690
Austin, TX 78716
1-800-845-7519
Fax 1-512-275-9350

GROUP ACCIDENT CLAIM FORM

Along with this completed claim form, please attach a copy of your bill for services, to include date(s) of service, charges and a detailed explanation of charges. If admitted, we will need date of admission and date of discharge. If you have any questions, please do not hesitate to call our claims department at the number above. Claims can be mailed, or faxed to the address/fax number noted above.

Certificate Holder/Claimant Information

CERTIFICATE HOLDER

Name of Certificate Holder _____ Date of Birth _____/ _____/_____

Certificate No. _____ SS No. _____

Phone No. _____ Email Address _____

Street Address_____

City: _____ State: _____ Zip: _____

Employer_____Occupation_____

CLAIMANT (IF DIFFERENT)

Name of Claimant _____ Date of Birth ____ / _____/_____

Relationship of Claimant to Certificate Holder_____

ACCIDENT CLAIM DETAILS:

Please provide the following details in regard to your claim.

Is this a new claim, or are you filing for additional benefits on existing claim? ☐ **New** ☐ **Existing claim, additional benefit**

* If existing, please skip to page 2 of claim form.

What is your Diagnosis/Condition _____

When did you first notice symptoms of your condition_____/____ / _____ is your condition work related? Yes No (please circle)

Have you ever had the same or similar condition? Yes No (please circle) If yes, when _____

Other conditions affecting your health _____

Is your condition due to an accidental injury? Yes No (please circle) If yes, date of accident _____/_____ /_____

How did the accident occur? _____

What was the injury that resulted from this accident/event? _____

Where did your accident occur?_____

Was a police report filed? Yes No (please circle) If due to a motor vehicle accident, were you the passenger or driver? _____

When did you first receive treatment for this accident? _____

Were you hospitalized as a result of this accident? Yes No (please circle) If yes, date admitted ___/___/_____ discharged ___/___/_____

Outpatient Office Visit Information:

- ☐ **Outpatient Physician Expense Benefit**: Please provide EOB, with date of service and reason for visit.

Accident Benefit Information:

Please indicate which of the following benefits are applicable to the claim and attach requested information.

- ☐ **Accident Medical Expense Benefit**: Please provide itemized bill, EOB, UBO4, or HCFA 1500 with date of service and reason for visit.
- ☐ **Immediate Hospitalization Benefit**: Please provide inpatient bill, or medical records showing inpatient hospitalization with dates of admission and discharge.
- ☐ **Daily Hospitalization Benefit**: Information provided above.
- ☐ **Daily ICU Confinement**: Please provide hospital bill, or medical records documenting date admitted to ICU and date moved from ICU.
- ☐ **Dislocation or Fracture Benefit**: Please provide itemized billing that includes details of injury.
- ☐ **Ambulance Benefit**: Please provide documentation in regard transport to medical facility.
  - ☐ Air **or**,
  - ☐ Land
- ☐ **Accidental Death & Dismemberment Benefit**
  - ☐ Death: Please provide a copy of death certificate and accident report.
  - ☐ Dismemberment: Please provide medical records documenting loss.

Additional Accident Benefit Riders

Only applicable if purchased at the time of sale. Please refer to your policy.

- ☐ Abdominal or Thoracic Surgery: Please provide explanation of procedures completed by surgeon.
- ☐ Accident Follow-up Treatment: Please provide bill, with date of service.
- ☐ Appliance: Please provide copy of prescription for appliance and copy of billed charges.
- ☐ Blood and Plasma: Please provide documentation of transfusion and reason prescribed.
- ☐ Brain Injury Diagnosis: Please provide medical documentation of the results from a CT scan, EEG, MRI, or PET scan for any brain injury that is a result of an injury, including contusion, cerebral laceration, concussion or intracranial hemorrhage
- ☐ Burn Please provide records to include degree and percentage of body affected.
- ☐ Coma: Please provide documentation of condition and date entered into and date recovered.
- ☐ Eye Injury: Please provide records to include type of treatment received.

Additional Accident Benefit Riders Continued

- ☐ Family Member Lodging: If confined in a non-local hospital, please provide a receipt for lodging costs for one family member who does not live within 60 miles of the facility.
- ☐ Laceration (cuts): Please makes sure itemized bill includes details.
- ☐ Non-local Transportation
- ☐ Paralysis: Please provide attending physician's statement.
- ☐ Physical Therapy: Please make sure itemized bill includes details to therapy, as well as dates of service.
- ☐ Prosthesis (hand, foot or eye only) Please: provided itemized bill and prescription by physician for prosthesis.
- ☐ Ruptured Disk: Please provide a physician's statement.
- ☐ Skin Graft
- ☐ Tendon, Ligament Rotator Cuff or Knee Cartilage (torn, ruptured, or severed): If, as a result of a benefit covered under the burn benefit, please provide an attending physician's statement to include type of injury and treatment received.

Instructions:

Please complete the Certificate Holder information in order for Leaders to determine who the coverage was taken and is being billed under. The claimant would be either the Certificate Holder, or a family member who was applied for under the Certificate Holder.

Please complete and provide the claim details under the Accident Claim Details section of the claim form. The benefits for which you are filing for will be completed under the Benefit Information section; and if applicable, the Additional Benefit Rider section of the form. The form will advise you as to what additional information is needed for each benefit that applies to your claim.

Both the claimant and Certificate Holder will need to sign and date the claim form. If the claimant is not the Certificate Holder, we will need the claimant's social security number, as this is not captured at the time of application. Please sign and date the claim form. Your signature will also allow Leaders to obtain any additional information necessary information to process your claim, such as medical records.

Authorization to Obtain Information

AUTHORIZATION. I AUTHORIZE: (a) any health plan, physician, healthcare professional, medical practitioner, hospital, clinic, laboratory, pharmacy or pharmacy related facility, medical facility, or other healthcare provider that has provided payment, diagnosis, treatment, care or services to me or on my behalf ("My Providers"); and (b) any insurance company, or other organization, institution or person that has records or knowledge of me or my health ("Other Persons"); to disclose my entire medical record, knowledge of my health and any other protected health information concerning me as permitted by law to the Company, its agents, employees, representatives, reinsurers and any medical or pharmaceutical records retrieval service the Company may engage. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers or with Other Persons to restrict my protected health information and I instruct My Providers and Other Persons to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

The use of disclosures authorized by this document is for the purpose of allowing the Company to: (1) underwrite my application for coverage, make risk rating determinations, and make policy issuance determinations; (2) obtain reinsurance; and (3) conduct other legally permissible activities that relate to any coverage I have applied for with the Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing at any time by sending a written request for revocation to Leaders Life Insurance Company, P.O. Box 35768, Tulsa, OK 74153, Attention: Privacy Officer.

I understand that a revocation is not effective if My Providers and Other Persons have relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed by the receiving party and no longer covered by certain federal rules governing privacy and confidentiality of health information. I understand that if I refuse to sign this Authorization, the Company may not be able to process my application.

I represent that all statements and answers in this claim form are complete, true and correctly recorded to the best of my knowledge and belief and that I have appropriate knowledge to answer the questions for my spouse and children.

Under penalties of perjury, I/we represent that the Social Security Number(s) provided herein is/are true, correct, and complete.

NOTICE: Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information may be guilty of a crime and may be subject to fines and imprisonment.

Applicable to OK residents: 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.

Applicable to AR and LA residents: Any person who knowing 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.

Applicable to KS residents: Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information may be guilty of insurance fraud as determined by a court of law.

Signed at (City) _____ State _____ this _____ Day of _____ 20 _____

X _____
Signature of Claimant

X _____
Owner (if other than Claimant))

Social Security Number of Claimant _____