Accident, Sickness, Heart Attack/Heart Disease/Stroke

Underwritten by: Humana Insurance Company
Administered by: Bay Bridge Administrators LLC

Claim Filing Instructions

Page 2 – 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 3 – Authorization

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

Pages 4 & 5 – Pre-existing Review Form

If claim is being filed within the first two years 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.

Pages 6 - Employer's Statement

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

Pages 7 & 8 - 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 statements 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:

Online Portal	E-mail	Mail	Fax
portal.bbadmin.com	claims@bbadmin.com	Bay Bridge Administrators, LLC PO Box 161690 Austin, TX 78716	512-725-9350

For questions, call: 800-845-7519

Claim Form for Accident, Sickness, Heart Attack/Heart Disease/Stroke	**Underwritten by: Humana 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 If yes, date: _____	Treated by: Hospital's Name: _____ Hospital's Address: _____ (Street, City, State, Zip Code) Physician's Name: _____ Physician's Address: _____ (Street, City, State, Zip Code)
Have you ever had the same or a similar condition in the past? ◯ Yes ◯ No If yes, date: _____	Treated by: Hospital's Name: _____ Hospital's Address: _____ (Street, City, State, Zip Code) Physician's Name: _____ Physician's Address: _____ (Street, City, State, Zip Code)

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 you 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 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, Parent, or Guardian	Relationship to Applicant	Date

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

If claim is being filed during the first two years of the policy, please complete the following and sign and date the authorization on the preceding page.

Please list all physicians that treated the patient in the last 5 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: _____

Insured Name: _____ Claimant Name: _____ Date: _____

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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portal.bbadmin.com	claims@bbadmin.com	Bay Bridge Administrators, LLC PO Box 161690 Austin, TX 78716	512-725-9350

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Employer's Statement

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

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Physician's Statement

To be completed by the Medical Provider		
Claimant 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:		

Medical Provider's Name (Please Print):	
Medical Provider's Phone Number:	Medical Provider's Fax Number:
Limitations (what the patient CANNOT do):	
Physical Impairment (*as defined in Federal Dictionary of Occupational Titles): ◯ **Class 1 –** 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:	
Medical Provider's Signature:	Date Signed:
Name of Physician (Please Print):	
Physician's Phone Number:	Physician's Fax Number:
Physician's Mailing Address:	

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State Specific Fraud Warning Statements

Arkansas
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.

California
For your protection, California law requires the following to appear on this form:
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.

District of Columbia
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

Kentucky
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.

Louisiana
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.

Maryland
Any person who knowingly and willfully 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.

New Jersey
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico
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 civil fines and criminal penalties.

North Carolina
Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Ohio
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.

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.

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.

Rhode Island
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.

Tennessee, Virginia 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 include imprisonment, fines, and denial of insurance benefits.

BAY BRIDGE ADMINISTRATORS

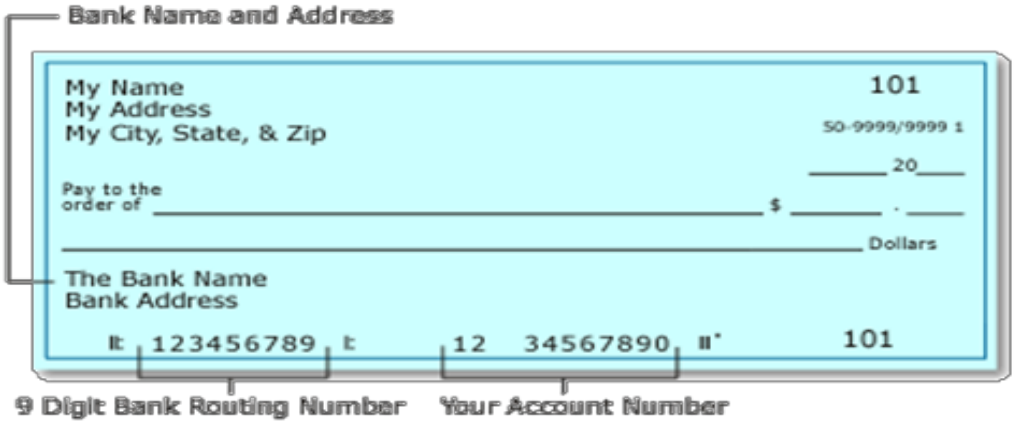
We are pleased to offer electronic ACH (Automated Clearing House) payments for your supplemental coverage benefit payments. ACH payments provide an alternative to paper checks, affording you the following advantages:

- 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

Enroll now and enjoy the convenience of direct deposit—no more waiting on paper checks or dealing with mail delays. Payments go straight to your bank account! You'll still receive your Explanation of Benefits (EOB) by mail, but why not take it a step further? Sign up for our Online Portal and access your EOBs anytime, anywhere. It's fast, secure, and easy to use. Activate your account now at portal.bbadmin.com and make the switch to a smoother, paperless experience!

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 # _____ 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)

☐ Electronic Communications Policy *Go Paperless Today!*
By accessing and using the Bay Bridge Administrators, LLC portal, you agree to receive electronic communications from us regarding your insurance policies and claims. Such electronic communications may include but are not limited to policy documents, claims correspondence, and notices. We may send these communications to you by email, text message, or other electronic means, and we may use automated technology to communicate with you.
By agreeing to receive electronic communications from us, you acknowledge and agree that: You have the necessary equipment, software, and internet connection to receive and access these communications. Your electronic acceptance of any communication is legally binding and has the same effect as a physical signature. You may withdraw your consent to receive electronic communications at any time by contacting us using the information provided on our website. However, withdrawing your consent may limit our ability to provide you with certain services. We may send you promotional or marketing messages as part of our electronic communications. You may opt-out of receiving such messages at any time. Please note that certain states require us to obtain your consent to receive electronic communications related to your insurance policies and claims.
By accepting this policy, you confirm that you have read and understood the terms of this Electronic Communications Policy and consent to receive electronic communications from us as described above. By signing electronically, I agree that my electronic signature is the legal equivalent of my manual/ handwritten signature. ***Activate your portal registration at portal.bbadmin.com.***

Authorized Signature _____ Date _____

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

BAY BRIDGE ADMINISTRATORS