Group Accident Claim Form

Please complete the form in full, then attach the documentation required for the benefit. If you have any questions, please call our Claims Department at the number listed below. Claims can be mailed, faxed or emailed to the address, fax or email listed below.

CERTIFICATE HOLDER INFORMATION

Full Name of Certificate Holder _____ Date of Birth _____

Certificate Number _____ Social Security Number _____

Phone Number _____ Email Address _____

Street Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

CLAIMANT INFORMATION (If different)

Full Name of Claimant _____ Date of Birth _____

Relationship of Claimant to Certificate Holder _____

SECTION I 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.

ACCIDENT CLAIM DETAILS - SECTION II ☐ Initial Claim ☐ Ongoing Claim-Skip Section II

What is your Diagnosis/Condition:_____

When did you first notice symptoms of your condition _____ Condition work-related ☐ Yes ☐ No

Have you ever had the same or similar condition? ☐ Yes ☐ No If yes, when _____

Other conditions affecting your health _____

Is your condition due to an accidental injury? ☐ Yes ☐ No 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 If due to a motor vehicle accident, were you the passenger or driver? _____

First received treatment for accident? _____ Were you hospitalized as a result of this accident? ☐ Yes ☐ No

If yes, date admitted _____ discharged date_____

LeadersLife INSURANCE COMPANY

Group Accident Claim Form, continued

SECTION III ACCIDENT BENEFIT INFORMATION - Indicate which benefits are applicable to claim, attach requested information.

☐ **Accident Medical Expense Benefit:** Please provide itemized bill, EOB, UBO4, or HCFA 1500 with date of service and reason for visit.

☐ **Outpatient Physician Expense Benefit:** Please provide the requested information below or an EOB, with date of service and reason for visit.

_____ _____ _____ _____

Full Name of Physician | Phone Number | Date of Visit | Reason for Visit

_____

Physician Address

☐ **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 to 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.

SECTION IV ADDITIONAL ACCIDENT BENEFIT RIDERS - Only applicable if purchased at 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 intra-cranial 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.

☐ **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:** Please provide prescription and documentation from ordering Physician that treatment cannot be obtained locally.

☐ **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 provide itemized bill and prescription by physician for prosthesis.

☐ **Ruptured Disk:** Please provide a physician's statement.

☐ **Skin Graft:** Please provide records documenting skin graft procedure, if it is a result of a benefit covered under the burn benefit.

☐ **Tendon, Ligament Rotator Cuff or Knee Cartilage (torn, ruptured, or severed):** Please provide an attending physician's statement to include type of injury and treatment received.

Authorization for Release of Information HIPAA Compliant

Full Name of Insured/Claimant Name _____ Date of Birth _____ Social Security Number _____

I hereby authorize all the people and organizations listed below to give Leaders Life Insurance Company and its authorized representatives, including agents and insurance support organization, (collectively, the "Recipient"), the following information:

- any and all information documents, treatment notes (including psychotherapy notes), consultation notes, and reports of diagnostic procedures relating to my health and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries ; hospital confinements for physical and mental conditions,; use of prescription drugs, use of drugs or alcohol; and communicable diseases including HIV or AIDS.
- any and all information relating to my occupations, my employment, or my activities.

I hereby authorized each of the following entities to provide the information outlined above:

- any physician or medical practitioner, hospital, clinic or other health care facility,
- any pharmacy or pharmacy benefit manager,
- any insurance or reinsurance company (including, but not limited to, the Recipient),
- any consumer reporting agency or insurance support organization,
- my employer, group policyholder, or benefit plan administrator,
- the Medical Information Bureau (MIB), and
- any other person or business.

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for coverage and/or benefits under an insurance policy; and
- detect insurance fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance company listed above is subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the Leaders Life Insurance Company's Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or where law allows the Recipient to contest a claim under the policy or to contest the policy itself , by sending a written request to: Leaders Life Insurance Company, P.O. Box 86, Bloomfield, CT 06002. I understand that my revocation of this authorization will not affect prior uses and disclosure of my health information by the Recipient for purposes of claim administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Recipient may not be able to obtain the information necessary to consider my claim for benefits.

I further understand an investigative consumer report may be requested concerning factors affecting my eligibility for insurance benefits. The factors which may be investigated include my activities, personal characteristics, mode of living, and health history. The report may be obtained through personal interviews with my friends, neighbors, and associates. I have a right to submit a written request to LeadersLife for a complete and accurate disclosure of the nature and scope of any such report.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Name of Insured/Claimant (print) _____ Date _____

Signature of Insured/Claimant/Guardian/Representative _____ Description of Authority of Personal Representative (if applicable) _____

LeadersLife INSURANCE COMPANY

Fraud Statement

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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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 **AL** residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Applicable to **AR** and **LA** residents: 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.

Applicable to **FL** residents: 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.

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.

Applicable to **NM** residents: 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.

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 **TX** residents: Any person who knowingly presents a false of fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signed at (city) _____ State_____this _____ Day of _____,20_____

_____ Signature of Claimant

_____ Signature of Owner(if other than Claimant)

Social Security Number of Claimant _____