PROSPERITY LIFE GROUP®

S.USA LIFE INSURANCE COMPANY, INC.

A Prosperity Life Group® Company

Administrative Office: P.O. Box 161690, Austin, TX 78716 Toll Free Phone: 877.909.6269

LIMITED BENEFIT GROUP SUPPLEMENTAL INSURANCE MEMBER CLAIM FORM

Please include your certificate number on your claim. If you need assistance locating your certificate number, please contact our Customer Care Center at 877-909-6269.

To avoid delays in processing, please fill out the sections and pages which apply to your claim. You may fax your completed claim form to 512-275-9350 or mail your form to:

Bay Bridge Administrators, LLC.
P.O. Box 161690
Austin, TX 78716

---

*This form is applicable to: **Inpatient and Outpatient Benefits**, if filing for any **Outpatient Rx Benefits** please use the "Limited Benefit Supplemental Outpatient Prescription Drug Member Claim Form".*

PLEASE READ THE FOLLOWING INSTRUCTIONS AND COMPLETE THIS FORM CAREFULLY.

1. **COMPLETELY FILL OUT PART 1 AND 2** (Part 3 is optional).
2. **SIGN AND DATE PART 4.**
3. **REMEMBER TO PROVIDE YOUR SOCIAL SECURITY NUMBER AND A COPY OF THE EXPLANATION OF BENEFITS (EOB) FROM YOUR MAJOR MEDICAL PLAN.**
4. **ATTACH A COPY OF YOUR UB-04 FORM FROM YOUR HOSPITAL OR CMS-1500 FROM YOUR PROVIDER.** These forms are the standard billing forms utilized by healthcare facilities and providers. Your documentation should provide complete information on:
    a. Provider's Name and Address
    b. Provider's Tax Identification and NPI Number
    c. Diagnosis Code (ICD-10)
    d. Charges/Cost of each Treatment.
    e. Procedure Code (CPT)
    f. Place of Service Code
5. **Please send this claim to the address provided on this form.**

FRAUD WARNING

For your protection, the laws of several states (including those listed below) require that we provide you with the following statements.

GENERAL FRAUD NOTICE: 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 may be guilty of a criminal offense and subject to penalties under state law.

Alabama: 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.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: FOR YOUR PROTECTION ARIZONA LAW REQUIRES THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, 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.

California and Texas: For your protection California and Texas law require the following to appear on this form: Any person who knowingly presents a 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.

Delaware and Idaho: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement or claim containing false, incomplete or misleading information is guilty of a felony.

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 in the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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 purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, 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 may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or any 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of claim for each such violation.

Ohio: 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 guilty of insurance fraud.

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.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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 containing any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claims to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

PART 1. NAMED INSURED INFORMATION (REQUIRED FOR ALL CLAIMS)

Full Name (As it appears on your Social Security card)	Policy/Certificate Number

Employer/Group Name	Employer/Group PhoneNumber

This claim is being filed for: ❑ Self ❑ Spouse ❑ Dependent

Date of Birth	Social Security Number

Mailing Address	City	State	Zip Code

Phone	E-mail

PART 2. PATIENT INFORMATION (IF CLAIM IS FOR SPOUSE OR DEPENDENT CHILD)

Full Name (As it appears on Social Security card)

Date of Birth	Social Security Number

Relationship	Phone Number

PART 3. PROVIDER INFORMATION

Would you like this claim to be paid out to your Provider? ❑ Yes ❑ No

If yes, please provide:

Provider's Name	Provider's Phone Number

Provider's Address

Provider's NPI #	Provider's Tax-ID

STEP 4: MEMBER SIGNATURE

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.

By signing you acknowledge that the above information is true to the best of your knowledge and belief.

Signature _____ Date: _____

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO BAY BRIDGE ADMINISTRATORS, LLC

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, Pharmacy Benefit Manager (PBM), medical facility, or other health care provider that has provided payment, treatment or services on behalf of the Insured named below within the past 10 years ("Providers") to disclose the entire medical record and any other protected health information concerning the Insured named below to Bay Bridge Administrators. LLC and its agents, employees, and representatives. This includes information on the diagnosis or 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 acknowledge that any agreements made to restrict such protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose such entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Bay Bridge Administrators. LLC may:

1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage the Insured named below has with Bay Bridge Administrators. LLC.

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. Except I understand that: (A) if the Insured resides in, or in the case of a death claim, was a resident at the time of death in, Arizona, Georgia, Illinois, Minnesota, New Jersey, New Mexico, North Carolina, Ohio or Virginia, this Authorization shall not remain valid for longer than: (1) the term of coverage of the policy if the claim is for a health insurance benefit; or (2) the duration of the claim if the claim is not for a health insurance benefit; and, (B) as to HIV-related information only, if the Insured resides/resided in Arizona, this Authorization shall remain valid for 180 days; and, (C) if the Insured resides in, or in the case of a death claim, was a resident at the time of death in Wisconsin, this Authorization shall remain valid for the policy term or the pendency of a claim for benefits under the policy, whichever is longer. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Bay Bridge Administrators. LLC at P.O. Box 161690, Austin, TX 78716, Attention: Claims Department. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that Bay Bridge Administrators. LLC 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 and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release the complete medical record of the Insured named below, Bay Bridge Administrators. LLC may not be able to make any benefit payments. I understand that the Insured or Insured's authorized representative may request a copy of this Authorization.

_____

Name of Insured or covered Dependent if over 18 (please print)

X_____ _____

Signature of Insured or Dependent if over 18 Date

_____

Description of Personal Representative's Authority