SHENANDOAH LIFE INSURANCE COMPANY

A Prosperity Life Group® Company

ACCIDENT CLAIM STATEMENT

Please include your certificate number on your claim. If you need assistance locating your certificate number, please contact our Customer Care Center at 844-801-6238.

To avoid delays in processing, please fill out the sections and pages that apply to your claim. You may submit your completed claim form via:

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

Instructions for Filing a Claim:

1. Complete Parts 1, 3, and 4 for all claims.
2. Complete Part 2 if filing for a Spouse or Dependent Child.
3. Complete Authorization for Release of Health Related Information (HIPAA) Part 5.
4. Attending Physician Statement (APS) Requirement - Part 6. Please submit a completed APS when a copy of the itemized bill or admit/discharge summary (including diagnosis) is not available. We reserve the right to request a completed physician statement as needed.
5. If death involved, please complete Part 7.
6. Provide Documentation:

   Attach an itemized bill or admit/discharge summary or medical records for each claim to be considered. Some documentation can be obtained by requesting a copy of the hospital bill (UB04) or HCFA1500 (non-hospital bill) from your healthcare provider. The medical documentation needs to include the date of service, the type of service and the name of the provider of the service.

   Please include the following documents for all that apply:

   Hospitalization: copy of hospital bill indicating diagnosis, services or treatment, and days hospitalized

   Surgery: a copy of the operative report

   Motor Vehicle Accident or any incident investigated by a law enforcement agency: a copy of the police report

   Death: Please submit a certified copy of the death certificate, which can be returned at your request.

   Other: copy of medical bills, physician records, ambulance charges, lodging and transportation expenses, and other appropriate documentation to support claim for benefits

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 Phone Number	Did injury result from employment?
	■ Yes ☐ No ☐ Currently Disputed

This claim is being filed for:	Marital Status:
☐ Self ☐ Spouse ☐ Child	☐ Married ☐ Single ☐ Divorced ☐ Widowed

Sex:	Date of Birth:	Social Security Number:
☐ Male ☐ Female		

Street Address

City	State	Zip Code

Phone Number:	E-mail Address:

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

Full Name (As it appears on Social Security card)	Relationship:

Sex:	Date of Birth:	Social Security Number:
☐ Male ☐ Female		

Phone Number	Did injury result from employment?
	☐ Yes ☐ No ☐ Currently Disputed

PART 3. CLAIM INFORMATION (IF NECESSARY, ATTACH SEPARATE SHEET)

Date and Time of Accident	Location of Accident

Description of Accident

PART 3. CLAIM INFORMATION (CONTINUED)	
Primary Physician Name	Phone & Fax Number
Primary Physician Address	
Hospital Name	Phone & Fax Number
Hospital Address	

In order for benefits to be considered, please provide documentation of services provided or performed related to the accident. The itemized documentation must include the name of the provider, date of service, type of service, and charge.

This could include some of the following depending on your plan. (Check all that apply)

- ❑ Treatment in the emergency room
- ❑ Accident follow-up care
- ❑ Hospitalization
- ❑ Intensive Care Unit (ICU)
- ❑ Treatment for specific injuries: burns, dislocation, coma, paralysis, fractures, lacerations, etc.
- ❑ Specified surgical procedures
- ❑ Accidental death
- ❑ Accidental dismemberment
- ❑ Ambulance
- ❑ Motor Vehicle Accident
- ❑ Appliance/Equipment (wheelchair, brace, crutches, walker, etc.)
- ❑ Blood/Transfusion/Oxygen/Other gases
- ❑ Lodging
- ❑ Major diagnostic exam
- ❑ Physical therapy
- ❑ Prosthesis
- ❑ Rehabilitation unit
- ❑ Transportation
- ❑ Disability (Named Insured)
- ❑ Other (child care, pet boarding, home modifications, vision and hearing aid damages, dental, prescription drugs, etc.)

Insured Name _____ Claimant Name _____ Date _____

PART 4. CLAIMANT STATEMENT AUTHORIZATION

Acknowledgement and Certifications

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notices included on this form.

New York Residents:

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.

_____ _____

Named Insured's Signature Date

_____ _____

Patient's Signature (if different than the Named Insured) Date
(Parent's signature acceptable if patient is a minor)

If signed as Power of Attorney, Guardian or Conservator, please attach a copy of the document granting that authority.

*By providing your e-mail address above, you consent to the use of electronic transactions in connection with our certificates, contract, and/or account to the extent available and permitted by law (which may include, but not limited to, invoices, claim correspondence, contracts, surveys, and other materials that is, or may be legally required to deliver to you).

PART 5. AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO SHENANDOAH LIFE INSURANCE COMPANY

Certificate Number

_____

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 Shenandoah Life Insurance Company 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 Shenandoah Life Insurance Company 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 Shenandoah Life Insurance 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. 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 Shenandoah Life Insurance Company at P.O. Box 12847, Roanoke, VA 24029, Attention: Chief Privacy Official. 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 Shenandoah Life Insurance 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 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, Shenandoah Life Insurance Company 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; or if death claim, Personal Representative or Beneficiary

Date

_____

Description of Personal Representative's Authority

PART 6. ATTENDING PHYSICIAN'S STATEMENT
(THIS STATEMENT MUST BE FILLED IN COMPLETELY BY A PHYSICIAN)

THE PATIENT IS RESPONSIBLE FOR ANY COSTS ASSOCIATED WITH THE COMPLETION OF THIS FORM.

Was the injury or death a direct result of an accident? ☐ Yes ☐ No ☐ Currently Disputed

To the best of your knowledge, was the injury the result of any of the following?

☐ Attempted Suicide ☐ Intoxication ☐ Use of drugs
☐ Committing a felony ☐ Self-inflicted ☐ Work-related
☐ Complication of treatment

Patient's Name _____

Patient's Date of Birth _____

☐ Male ☐ Female

Date of Accident _____

Diagnosis _____

First Consult Date _____

Primary ICD-10 Code(s) _____

Primary CPT Code(s) _____

Is this a new injury? ☐ Yes ☐ No

Have you treated the patient for this or a similar condition before? ☐ Yes ☐ No

If still being treated, referring Physician Name and Address: _____

_____

_____

Continuing/ongoing treatment expected or prescribed; anticipated end date: _____

Any limitations? ☐ Yes ☐ No

If so, please describe: _____

_____

_____

_____

PART 6. ATTENDING PHYSICIAN'S STATEMENT (CONTINUED)

Hospital Name _____

Hospital Address _____

_____

Date and time of Admission _____

Date and time of Discharge _____

☐ Inpatient ☐ Outpatient ☐ Emergency Room ☐ Intensive Care Unit

Attending Physician Name _____

Specialty _____

Address _____

_____

_____

Telephone Number _____

Fax _____

_____ _____

Attending Physician Signature Date

PART 7. DEATH BENEFIT PROCEEDS FORM

Instructions for Completing this Form

1. **Claimant's Information**
   a. This form should be completed in full detail by the named beneficiary before a witness who should sign the form. If there is more than one beneficiary, each one should complete a separate form.
   b. If the beneficiary is an Estate, the form should be completed by the Executor or Administrator of the Estate and should be forwarded to the Company accompanied by the properly certified letters of administration. Where a beneficiary signature is required, it shall be understood that the individual signing is signing in his or her capacity as the Executor or Administrator of the Estate.
   c. If the beneficiary is a Trust, the form should be completed by the Trustee of the Trust. Where a beneficiary signature is required, it shall be understood that the individual signing is signing in his or her capacity as the Trustee of the Trust.
   d. If the beneficiary is a minor, claim for the benefit should be made by his or her legal appointed guardian and certified letters of guardianship should be furnished. Where a beneficiary signature is required, it shall be understood that the individual signing is signing in his or her capacity as the Guardian of the minor beneficiary. In the event no guardian is to be appointed, contact Shenandoah Life for further instructions.
2. **Certified Death Certificate** – A certified death certificate with cause of death for the Insured should be provided.

INFORMATION ABOUT THE DECEASED

Name of Deceased in Full	Date of Birth

Other Names Used by the Deceased

Please provide the Policy or Certificate Numbers(s) under which the claim is made:

Cause of Death	Date of Death

Was the cause of death due to an accident? (If "Yes", additional documentation may be required)
☐ Yes ☐ No

INFORMATION ABOUT THE CLAIMANT

You are completing this form as: ☐ Beneficiary ☐ Executor ☐ Administrator ☐ Trustee ☐ Assignee ☐ Guardian

☐ Other: (explain) _____

Date of Birth	Claimant's Social Security Number (SSN) or Tax Identification Number (TIN)	☐ Male ☐ Female

Under the penalties of perjury by signing below, I certify that:

a) The Taxpayer ID Number or Social Security Number above is my correct number (or I am waiting for a number to be issued to me), and

b) I have not been notified by the Internal Revenue Service that I am subject to a back-up withholding order on interest and dividends (if you have been so notified, cross out this entire statement) and

c) I am a U.S. person (including a U.S. resident alien).

PART 7. DEATH BENEFIT PROCEEDS FORM (CONTINUED)

Acknowledgement and Certification

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notices included on this form.

New York Residents:

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.

_____

Claimant's Name

_____ _____

Claimant's Signature Date

Claimant's Address _____

(Street Address, City, State, Zip Code)

Home Phone Number _____ Business Phone Number _____

Email Address _____

_____ _____

Witness Signature Date

PART 8. STATE FRAUD WARNINGS NOTICES

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

General Fraud Warning:

Any person who knowingly presents a false or fraudulent claim for payment for 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 Fraud Warning:

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 Fraud Warning:

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 Fraud Warning:

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 Fraud Warning:

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 Fraud Warning:

For your protection California and Texas law requires 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 Fraud Warning:

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 Fraud Warning:

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 Fraud Warning:

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 Fraud Warning:

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 Fraud Warning:

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.

PART 8. FRAUD WARNINGS (CONTINUED)

Kansas Fraud Warning:

Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky Fraud Warning:

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine, Tennessee, Virginia and Washington Fraud Warning:

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 Fraud Warning:

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 Fraud Warning:

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 Fraud Warning:

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

Ohio Fraud Warning:

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 Fraud 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 Fraud Warning:

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 Fraud Warning:

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 Fraud Warning:

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 claim 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 Fraud Warning:

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.

BAY BRIDGE ADMINISTRATORS

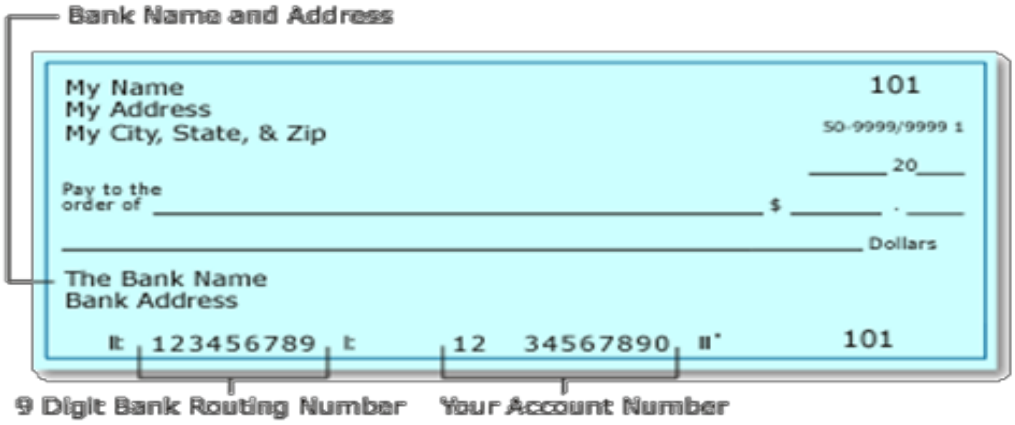
We are pleased to offer electronic ACH (Automated Clearing House) payments for your supplemental coverage benefit payments. ACH payments provide an alternative to paper checks, affording you the following advantages:

- 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