State Mutual Insurance Company

Platinum® SUPPLEMENTAL INSURANCE
Toll Free 866.326.4184

Accident Medical Claim Form

Please read and follow these instructions should there be a need to file a claim for a covered accident.

- Your policy says you must notify us of your claim and submit complete proof of loss (completed and signed claim form and itemized bills) within 90 days of the accident. Additional bills related to the accident should also be sent within 90 days of treatment.
- Your plan requires treatment must be sought within a specific time frame. Please refer to the Benefits Section in your rider for the initial treatment period.
- The claim form must be completed and signed by the Insured. Please make sure your policy number is on the claim form. Also, the "Authorization for the Use and Disclosure of Information" must be signed, dated and included with your submission.
- Please attach the itemized bills to the claim form. A balance due bill from your provider is not sufficient.

  An itemized bill is a statement that includes:

  1. Your, and/or the Covered Person's name and policy number;
  2. Health care provider's name, address and phone number;
  3. Health care provider's tax identification number;
  4. Place where service was received;
  5. Date service was received;
  6. Diagnosis of Sickness or Injury using ICD-CM codes (if an Injury, provide the date it happened) and the description of the service received using CPT and/or HCPCS procedure codes.
  7. Charges for each service received.
- Please include a copy of any official report of your accident i.e. Motor Vehicle Accident Report or Police Incident / Investigation Report.

Processing delays may result if we are not provided the above information

- Return the completed form, signed authorization and itemized bills to:

State Mutual Insurance Co. – Platinum Claims
PO BOX 1404
Rome, GA 30162 - 1404

- If you prefer payment to go directly to the medical provider, please complete and sign the authorization at the bottom of the claim form. Please indicate which bills have been paid by you.
- A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, policy number and date of accident.
- We suggest you make photocopies of any correspondence sent to our office to keep for your own records.

If you have any questions,
please contact our Claims Department.

855-774-4495

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Accident Medical Claim Form

To Be Completed By Insured

Policy Number _____

Name of Insured _____

Address _____
Street City State ZIP

Phone Number _____ Insured Date of Birth _____

Patient's Name and Relationship (if other than Insured) _____

Patient's Date of Birth _____ Male ❑ Female ❑

1. Date of Accident _____ a. Time of Accident _____ AM ❑ PM ❑
2. Description of Accident
   a. How did it occur? _____
   _____
   b. Where did it occur? City _____ State _____ Location _____
   c. Nature of Injury _____
3. Have you ever had this condition before? .....Yes ❑ No ❑
   If yes, please give month, date and year _____
4. Hospital or other provider name and address: _____
   City _____ State _____ Zip _____

PLEASE NOTE: Incomplete claim forms will result in processing delays.

I HEREBY AUTHORIZE State Mutual Insurance Company to pay benefits directly to the Hospital or Other Medical Provider as Indicated below. I understand that I am financially responsible to the Hospital or Other Medical Provider for their charges.

_____ _____
Signature of Insured Date

_____ _____
Hospital or Other Medical Provider Name Address

I understand that this information will be used by State Mutual Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

Insured Signature _____ **Date** _____

Print Name _____

For your protection state law requires the following statements to appear on this form.	
FRAUD WARNING STATEMENT	
Alabama	Any person who knowingly presents 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.
California	For your protection California 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	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.
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 York	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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
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	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.
Residents of All Other States	WARNING: Any person who knowingly files a claim containing false, incomplete, or misleading information with intent to injure, defraud or deceive is guilty of a crime and may be subject to civil and criminal penalties. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
The furnishing of forms does not constitute an admission of liability on the part of the Company.	

Authorization for the Use and Disclosure of Information

I hereby authorize State Mutual Insurance Company to use and/or disclose the following information about me as described below. **I understand that the information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations**.

Policy Number: _____ ____/____/____
Date of Birth

_____
Full name of insured whose information is being requested for use/disclosure

1. Persons/class of persons authorized to use or make disclosure of the information: ***Any health care providers from whom you sought treatment or received consultation.***

2. Name and address of persons/class of persons authorized to receive the information: ***State Mutual Insurance Company staff with appropriate access clearance to use and disclose the applicable information.***
3. Specific description of information that may be used/disclosed:
   - ☐ **Medical Information** (such examples may include, but is not limited to, the following: Explanation of Benefits, medical records, dates of services, amounts payable, health care provider information, services rendered, claim information, etc.)
   - ☐ **Other**, please specify: _____

4. The information will be used/disclosed for the following purposes (*all* purposes must be listed and described):
   - ☐ **Benefit/Payment Purposes** (examples include, but are not limited to, the following: for processing my claims and servicing my coverage, explanation of benefits, assessment of coverage needs)
   - ☐ **Other**, please specify: _____

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I further understand as a consequence of my failure to sign this authorization, State Mutual Insurance Company may not be able to process my claim for insurance benefits, resulting in a claim denial. I understand that State Mutual Insurance Company requires the information sought through this authorization to determine claim eligibility under the policy contract.

(Continued)

6. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:
   a. State Mutual Insurance Company or another third party has taken action in reliance on this authorization; or
   b. this authorization is obtained as a condition for obtaining insurance coverage, other law may provide State Mutual Insurance Company with the right to contest a claim under the policy or the policy itself.

   I understand to revoke my authorization I should send my written revocation request to:

State Mutual Insurance Co. – Platinum Claims
PO BOX 1404
Rome, GA 30162 - 1404

7. This Authorization will expire 24 months (180 days in Arizona and 12 months in Maryland) from the date of signature.

If you are signing as a personal representative for the policyholder, please read and sign below.

I,_____, hereby certify and attest that I am the duly authorized personal representative of_____, that my relationship to the policyholder is_____, and that I have the lawful authority to enter into this authorization on behalf of the policyholder. I have read the provisions set forth in this authorization, and agree that State Mutual Insurance Company may use and/or disclose the aforementioned information for the purposes set forth herein.

_____ _____
Signature of Individual or Personal Representative *Date*

_____ _____
Printed Name of Individual or Personal Representative *Relationship of Personal Representative or Authority to Act for the Individual*

You will be provided a copy of this signed Authorization.