

Life Insurance Company

Accident Expense Claim Form
CLAIMANT STATEMENT

If your policy includes the Short-Term Disability Income rider or Loss of Time benefits and you wish to file a disability claim, please refer to Disability Income claim forms.

Please consult your policy language for provisions and policy specific benefits.

When submitting your claim, you must include an itemized billing showing the date of service, amounts charged, diagnosis and procedure codes. This information can be obtained from the patient's healthcare provider(s) by requesting an itemized bill, HCFA 1500 non-hospital bill or a UB04 hospital bill. If the required information is not received, the claim may be delayed or denied.

1. Policyowner's name			Policy/Certificate no. 4151474402		
Street address		City		State	ZIP+4
Address					
Phone no.	Social Security no.	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		Policyowner's date of birth	
First		Middle		Last	
2. Name of claimant (if other than Policyowner)				Date of birth	
3. Occupation		Employer's contact no.			
Name		Street address		City	State
4. Employer		ZIP+4			
5. Date your physician first treated you (MM/DD/YYYY)		Other dates of treatment			
6. Date of the accident (MM/DD/YYYY)		Time of day			
7. Did the accident happen at work?		Please provide a copy of the accident report.			
8. Please provide a brief description of the accident					
Upon examining the leg we noticed he had an open wound and large knot on the lower leg. The leg was swelled and painful from the open wound. He had to be carried off the field and taken to the er.					
9. If you are applying for Accidental Death or Common Carrier benefits, please provide: 1) certified death certificate and 2) motor vehicle or police report.					

Claims can be faxed to (800) 869-0368 or mailed to at the address on the top of this form.

FRAUD NOTICES

Unless specific state language is provided below for your state of residence, the following general fraud notice applies.

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 a substantial civil penalty where and to the extent allowed by state law.

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.

AR, DC, LA, MA, RI 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.

AZ RESIDENTS: 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.

CA RESIDENTS: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO RESIDENTS: 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.

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FRAUD NOTICES (continued)

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.

IL RESIDENTS: 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 fraud or intentional misstatements of material fact commits a fraudulent insurance act, which is a crime and subject to a substantial civil penalty where and to the extent allowed by state law.

KS RESIDENTS: 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 may be a crime as determined by a court of law and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

KY RESIDENTS: 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.

MD RESIDENTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly or willfully presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

ME, TN, WA RESIDENTS: 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.

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

NC RESIDENTS: 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 may also be subject to a substantial civil penalty where and to the extent allowed by state law.

NH RESIDENTS: 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.

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

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.

NY RESIDENTS: 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH RESIDENTS: 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.

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.

OR RESIDENTS: Any person who knowingly and with intent to defraud an insurance company or any other person presents a false claim for payment of a loss or benefit may be guilty of insurance fraud and subject to civil fines and criminal penalties. If such misinformation is material to the content of the contract, relied upon by the insurer and either material to the risk assumed by the insurer or provided fraudulently, such action may also lead to denial of insurance benefits.

PA RESIDENTS: 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.

VA RESIDENTS: Any person who, with the intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

VT RESIDENTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I hereby acknowledge that I have read the applicable notice above.

I hereby certify the statements above are complete and accurate to the best of my knowledge.

Signature of Policyowner

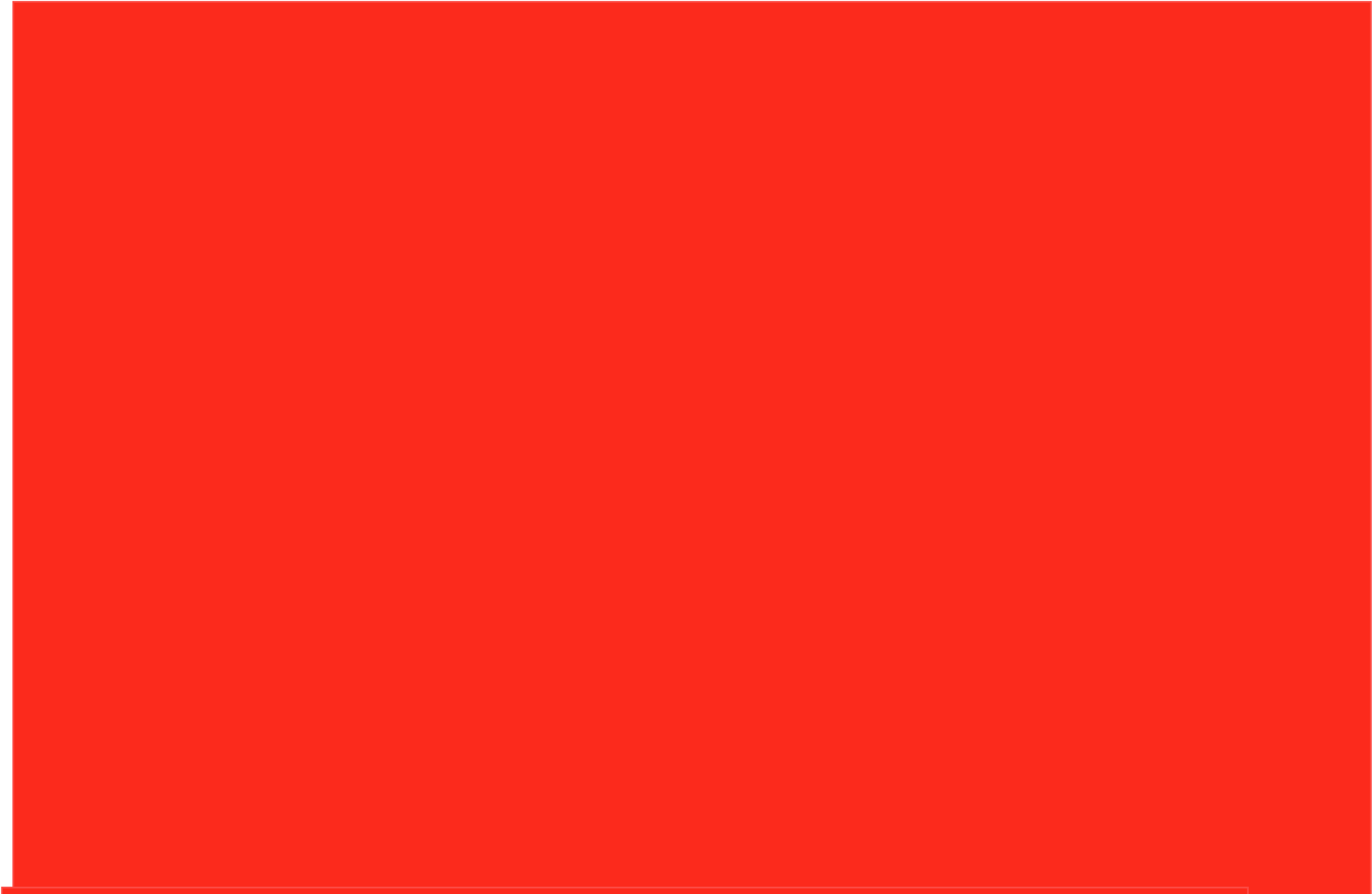
Signed by:
[Redacted Signature]
AA5DAB7968C8441...

Date (MM/DD/YYYY) 8/18/2024

Confidential Information
Authorization

Keshia Chitwood	09 / 18 / 1991
Legal Name of Applicant/Insured/Claimant (Please print)	Date of Birth (MM/DD/YYYY)
	/ /
Legal Name of Additional Applicant/Insured/Claimant (Please print)	Date of Birth (MM/DD/YYYY)

Applicant/Insured/Claimant: List child(ren) and date(s) of birth			
Legal Name	Date of Birth	Legal Name	Date of Birth
Noah Carter	04 20 2012		



ization,

This authorization complies with the Health Insurance Portability and Accountability Act of 1996. 

8/18/2024

Date (MM/DD/YYYY) Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18

Signature of Additional Applicant/Insured/Claimant or Legal Representative Signature of Applicant/Insured/Claimant Child (if age 18 or older)

Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT