
# NOTE: Please read this before submitting a claim.

## Instructions for filling out an Accident Medical Claim form.

- The claim form must be completed and signed by the insured. Please indicate your Group name on the claim form.
- Your Accident Medical plan requires that treatment must be sought within a specific time frame. Please refer to your Certificate of Insurance.
- Proof of loss (Completed claim form and itemized bills) should be submitted **within 90 days of the accident**. Additional bills related to the accident should be submitted **within 90 days of treatment**.
- You are required to provide medical records documenting all treatment received from all treatment providers consulted within the timeframe beginning three months prior to your reported accident through present date. Lack of receipt of all medical records as noted above will result in a delay in the review of your claim.
- Please attach itemized bills to the claim form. A balance due bill from your provider is **not** sufficient. An itemized bill is a statement that indicates:
    1) The date(s) of treatment,
    2) The type(s) of service,
    3) The diagnosis,
    4) The medical provider's name and address,

- Return the completed claim form, Authorization for Release of Health-Related Information, itemized bills and other insurance payment or denial (Explanation of Benefits) statements (if applicable) to

*FCE Benefit Administrators, Inc.*
*4615 Walzem Rd.*
*San Antonio, TX 78218*
*800-298-7269*
*Fax 210-610-5468*

- Please indicate which bills have been paid by you. If you prefer payments to go directly to the medical provider, please complete and sign the authorization at the bottom of the claim form.
- 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, group name, and date of accident.
- We suggest that you make photocopies of any correspondence sent to our office to keep for your own records.
- By furnishing forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

**IMPORTANT:**

Please take note: delays in the processing of your claim will occur if all of the following have not been provided to our company: the completed claim forms, the itemized bills from your medical provider, and a copy of your other insurance payment or denial (Explanation of Benefits) statement.

**PLEASE NOTE: Incomplete claim forms will result in a delay in the processing of your claim.**

# GROUP ACCIDENT MEDICAL EXPENSE CLAIM FORM

## TO BE COMPLETED BY THE INSURED:

Group Name: _____ Name of Insured: _____
First Initial Last

Insured Date of birth: _____ Social Security number: _____

Address: _____
Street City State Zip Code

Telephone number: _____ Email address: _____

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

Patient's Date of birth: _____ ☐ Male ☐ Female

Date and time of accident: _____

Where did the accident occur (Please include specific address): _____

Please describe the Injury sustained as a result of the accident: _____

_____

_____

Please describe, in detail, the specific circumstances surrounding the accident: _____

_____

_____

Was this a work related accident / injury: ☐ Yes ☐ No Are you self-employed: ☐ Yes ☐ No

Was a claim filed due to this accident / injury with your Workers' Compensation carrier: ☐ Yes ☐ No

If yes, please indicate the name and telephone number of your Workers' Compensation carrier: _____

_____

If no, please explain why: _____

Have you ever had this condition before: ☐ Yes ☐ No If yes, please indicate month, date, and year: ____/____/____

**I hereby authorize Fidelity Security Life Insurance Company to pay bills in connection with this accident 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 charges not covered by the policy.**

_____ _____
Signature of Insured Date

_____ _____
Hospital or Other Medical Provider Name Hospital or Other Medical Provider Name

_____ _____
Address / Telephone number Address / Telephone number

**The information I have provided on this form is accurate to the best of my knowledge.**
**I have received and read the fraud warning statements provided with this form.**

**Signature:** _____ **Date:** _____

**FIDELITY SECURITY LIFE INSURANCE COMPANY®**
P.O. BOX 418131 • 3130 BROADWAY • KANSAS CITY, MO 64141-8131
800-648-8624 (ALL AREAS) • FAX 816-968-0575

# AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

I authorize the disclosure of health information regarding, or related to:

Name: _____ Date of Birth _____ Policy No. _____
Claim No. _____

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This Authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to: (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this Authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations such as MIB, Inc. ("MIB"), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize Fidelity Security Life Insurance Company®, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this Authorization to administer the above referenced individual's health insurance coverage. I authorize Fidelity Security Life Insurance Company or its reinsurers to make a brief report of my protected health information to MIB.

A photographic copy of this Authorization shall be as valid as the original. I agree that this Authorization shall be valid for two years from the date shown below.

I understand that my providers may not refuse to provide treatment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Fidelity Security Life Insurance Company may not be able to make any benefit payments. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Fidelity Security Life Insurance Company at P.O. Box 418131, Kansas City, MO 64141-8131, Attention: Privacy Officer.

I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and once re-disclosed, may no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that I will receive a signed copy of this Authorization.

► _____ _____

Signature of the individual or the individual's personal representative — Date

If signed by the individual's personal representative (e.g., a parent on behalf of a child), describe your authority to sign on behalf of the individual.

**GENERAL FRAUD NOTICE: NOTE TO ALL PARTIES COMPLETING THIS FORM:** Any person who, with intent to defraud or knowing that he or she 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.

**FRAUD NOTICE: For the states of AL, AZ, AR, CO, DE, DC, FL, GA, IN, KS, KY, LA, MD, ME, NC, NE, NH, NJ, NM, OK, OR, PA, RI, TN, TX, VA, VT, WA and WV, please refer to the following fraud notices:**

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of 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.

**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, Louisiana, Rhode Island, West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of 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.

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

**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.

**Georgia, Oregon, Vermont:** Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**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.

**Kansas:** Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

**Kentucky:** 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.

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

**Maine, Tennessee, 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.

**Nebraska:** Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing false, incomplete or misleading information is guilty of insurance fraud.

**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 any false or misleading information is subject to criminal and civil penalties.

**New Mexico:** 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.

**North Carolina:** Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

**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.

**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.

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

**Virginia:** Any person who, with the 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 may have violated state law.