

HOSPITAL INDEMNITY CLAIMS INSTRUCTIONS - Please refer to your policy for your exact benefits - your plan may not contain each of the benefits shown.

All Claims are submitted using American Public Life **Claim Form C101**.

EMERGENCY ACCIDENT RIDER CLAIMS

Complete the section entitled "Claimant's Statement". Please be sure to date and sign in the blanks provided at the bottom of the form.

Submit the statement from the physician or emergency room that shows the date of service, the diagnosis (ICD-9 codes), the procedures performed (CPT codes) and the itemized charges. The statement should show the name, address and tax identification number of the physician.

A copy of the police accident report is required for all accidents investigated by any law enforcement agency.

HOSPITAL CONFINEMENT AND ANNUAL FIRST OCCURRENCE BENEFIT CLAIMS

Complete the section entitled "Claimant's Statement". Please be sure to date and sign in the blanks provided at the bottom of the form.

The claim form should be submitted with a copy of your itemized hospital bill that shows the number of days you were confined to the hospital, the amount charged and the diagnosis.

A copy of the police accident report is required for all accidents investigated by any law enforcement agency.

OUTPATIENT SICKNESS RIDER CLAIMS

Complete the section entitled "Claimant's Statement". Please be sure to date and sign in the blanks provided at the bottom of the form.

Submit the statement from the physician or emergency room that shows the date of service, the diagnosis (ICD-9 codes), the procedures performed (CPT codes) and the itemized charges. The statement should show the name, address and tax identification number of the physician.

A copy of the police accident report is required for all accidents investigated by any law enforcement agency.

SURGICAL AND ANESTHESIA BENEFIT CLAIMS

Complete the section entitled "Claimant's Statement". Please be sure to date and sign in the blanks provided at the bottom of the form.

Submit the bill from the surgeon that shows the diagnosis (ICD-9 code), the procedure code (CPT) for the surgery performed and the charge.

Submit bill from the anesthesiologist that shows the procedure code (CPT) and the charge.

WELLNESS BENEFIT / DIAGNOSTIC TESTING CLAIMS

Complete the section entitled "Claimant's Statement". Be sure to date and sign in the blanks provided at the bottom of the form.

The physician's itemized statement of services rendered must accompany the claim form. This is the walkout statement you receive from the doctor's office at the end of your appointment.

For diagnostic testing performed in an imaging center, please submit the bill from the imaging center.

INTENSIVE CARE / CORONARY CARE CLAIMS

Complete the section entitled "Claimant's Statement". Please be sure to date and sign in the blanks provided at the bottom of the form.

Submit the hospital bill that shows the itemized charge for each day of confinement to Intensive Care or Coronary Care.

All claims should be submitted to:

American Public Life Insurance Company
Attention: Claims Department
P. O. Box 925
Jackson MS 39205-0925

Do you have a question?

You may contact our Claims Department staff by calling 1-800-256-8606. Our fax number is 601-939-4495.

AMERICAN PUBLIC LIFE INSURANCE COMPANY

P.O. BOX 925, JACKSON, MISSISSIPPI 39205-0925 • (601) 936-6600 or 1 (800) 256-8606

Policy Nos.: _____

S.S.#: _____

CLAIMANT'S STATEMENT: Complete for all claims.

Policyholder's Name: _____ S.S.#: _____ Date of Birth: _____

Address: _____ Home Phone (____) _____

Employer: _____ Occupation: _____

Answer if Dependent's Name: _____ Relationship: _____

Claim is on Date of Birth: _____ S.S.#: _____

Dependent Is Dependent Employed? Yes No Employer: _____

Is Dependent a Student? Yes No School: _____

IMPORTANT: SUBMIT A COPY OF THE POLICE REPORT IF THIS CLAIM IS DUE TO A VEHICLE ACCIDENT.

SUBMIT A COPY OF THE PATHOLOGY REPORT IF THIS CLAIM IS DUE TO CANCER.

1. CLAIM IS FOR: Accident Illness Nature of Illness/Injury: _____

2. Date of Accident or 1st Sign of Illness: _____ If claim is for an Accident, describe how and where it occurred: _____

3. Has claim been made or will claim be made under any Worker's Compensation or Employers Liability Law? Yes No

4. Were you hospitalized? Yes No If yes, give dates, from _____ to _____
Mo. Date Yr. Mo. Date Yr.

Name/Address of Hospital: _____

If you were hospitalized, send a copy of the hospital bill.

5. List all the Doctors you have seen for this condition.
Name Address Date 1st Seen

6. Have you ever had symptoms of this condition before? Yes No When: _____

7. Do you have insurance with any other company? Yes No If yes, provide: _____
Name of Company Policy Number(s)

Complete this Section only if you are filing for disability (loss of time from work) benefits. NOTE: FAXED CLAIM FORMS ARE NOT ACCEPTED FOR DISABILITY CLAIMS. THE ORIGINAL FORM IS REQUIRED.

1. Date you stopped working due to disability: _____ Date you returned, or will return, to work: _____

2. Are you confined (restricted by Drs. Orders) to your home? Yes No

3. Average Monthly Earnings? \$ _____ 4. List Job Duties: _____

AR and LA: 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. **FL** 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. **IN and NV:** 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 concerning a material fact is guilty of insurance fraud. In **IN** insurance fraud is a felony. In **NV** insurance fraud is a category d felony. **KY:** 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. **NM:** Any person who knowingly presents 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 and confinement in prison. **OH:** 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:** 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:** 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. **TN:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. **VA:** 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. **PA:** 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.

By signing below I certify the above information is true and CORRECT to the best of my knowledge.

Policy Owner Signature: _____ Claimant Signature: _____ Date: _____

EMPLOYER'S STATEMENT: Must be completed for disability benefits.

1. Date of first absence due to disability: _____ Date employee returned or will return: _____
2. Date hired: _____ Date of termination if Employee is terminated: _____
3. Date of retirement if Employee is retired: _____ Did Employee take disability retirement? _____
4. **REQUIRED:** If the Employee pays the premium for this plan through payroll deduction, is the premium sheltered under a Section 125 (cafeteria) plan? _____ Is the premium paid by the employer as an employee benefit? _____
5. Has claim or will claim be made for Worker's Compensation Benefits? _____ If "yes", what is status of the claim? _____
6. Will you provide "light duty" if employee is released with restrictions? _____
 Name of Employer: _____ Phone number of Employer: _____
 Authorized Signature: _____ Title or Position: _____ Date: _____

PART B ATTENDING PHYSICIAN'S STATEMENT

For routine FIRST-AID claims, this side is not usually required, if a copy of the bill showing Patient's name, diagnosis, charges, and date incurred is furnished along with Claimant's Statement on reverse side.

1. Diagnosis and concurrent conditions. Please provide ICD-9 codes. (If diagnosis code other than ICD used, give name) _____
2. Is condition due to injury or sickness arising out of patient's employment? Yes No
3. If condition is due to an accident, please give details of the accident. _____
4. Is condition due to pregnancy? Yes No If Yes, expected date of delivery: _____ Date of LMP: _____

5. Report of services (or attach itemized bill). If a previous form has been submitted to this carrier, you need to show only dates and services since last report.

Date of Services (Mo., Day, Yr.)	Place of Services	Description of Surgical or Medical Services Rendered	Procedure Code – If used (If code other than CPT used, give name)	Charges
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

- | | |
|--|---|
| 6. Date symptoms first appeared or accident happened. _____ | 7. Date patient first consulted you for this condition. _____ |
| 8. Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" when and describe: _____ | 9. Patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date last seen: _____ |
| 10. Patient was continuously totally disabled (unable to perform substantially all of his/her occupational duties)
From _____ Through _____ | 11. Patient was partially disabled (able to perform some but not all of his/her occupational duties)
From _____ Through _____ |
| 12. If still disabled, date patient should be able to return to work? _____ | 13. Patient was hospital confined: From _____ To _____
Patient was house confined: From _____ To _____
(House confinement is the inability to leave the house except to obtain medical treatment or to engage in medically prescribed activities that are therapeutic in nature). |
| 14. Does patient have other health coverage? If "Yes", please identify. _____ | 15. Was patient referred to you by another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please provide name of referring physician. _____ |

Physician's Name (Please Print): _____ IRS Identification No.* : _____
 Physician's Signature: _____ Degree: _____ Date: _____
 Address: _____
 Street City State or Province Zip Phone Number (include area code)

* THE INSERTION OF THE IRS NUMBER IS REQUIRED BY THE INTERNAL REVENUE SERVICE.



American Public Life Insurance Company

A member of the American Fidelity Group

2305 Lakeland Drive, Jackson, Mississippi 39232
(601) 936-6600 • (800) 256-8606

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize any physician or practitioner of the healing arts, hospital, clinic or medically related facility, pharmacy, insurance company, health maintenance organization, medical information bureau, Worker's Compensation carrier, Social Security office, Veterans Administration, retirement system, government entity (federal, state or local) or other organization, institution or person to release any information regarding the medical or mental health history, treatment, disability or benefits payable for medical care or disability to the American Public Life Insurance Company or its representative. A photocopy of this authorization shall be as valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed, except release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from date signed. I understand that this authorization may be revoked at any time by providing written notice to American Public Life Insurance Company **except to the extent that American Public Life has taken action in reliance of this authorization or to the extent that law allows American Public Life to contest claims or coverage. Written notice must refer to the authorization by indicating the date it was signed and should be mailed to APL Claims Department, P O Box 925, Jackson MS 39205-0925.** By signing below I certify the above information as true and CORRECT to the best of my knowledge.

American Public Life may use this information to determine what, if any, benefit can be provided for any American Public Life coverage for which I may be eligible.

By State Law, you must be advised that:

THE INFORMATION YOU AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME ("AIDS").

The information you authorize for release may include your history of treatment for physical and/or emotional illness to include psychological testing (but not psychotherapy notes) and treatment records of alcohol and drug abuse.

You do have the right to refuse to sign this authorization; however, failure to sign the authorization may result in a denial of benefits.

American Public Life Insurance Company and its reinsurers agree to maintain the confidentiality of all the Insured's nonpublic financial or medical information given to us by any authorized entities listed above; **however, federal law (HIPPA) requires you be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and is no longer protected by HIPPA rules.**

Signature: _____ Date: _____

Print Your Name: _____ Name of Claimant: _____

If a personal representative signs this authorization, a description of the authority to act on behalf of the Insured must be included.

RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR PERSONAL RECORD.