

INSTRUCTIONS FOR FILING AN ACCIDENT CLAIM

The forms must be completed by the claimant. If the claimant is a minor, the primary insured parent must complete the forms. All questions on the forms must be answered in full. Incomplete or illegible answers may result in the delay of claim consideration. Please return the requested information as soon as possible for prompt processing.

The claimant is responsible for this information without expense to the Company.

- The enclosed **Statement of Claim** should be fully completed by the primary insured and the patient. Please make sure the Authorization at the bottom of the page is signed and dated.
- Please provide a copy of the **Accident Report**, if one is available.
- Please provide an **Itemized Emergency Room Bill**
- Please provide copies of itemized bills and/or treatment notes for any other related treatment, such as hospital, physician, physical therapist or ambulance bills.
- The enclosed **HIPAA** form, Authorization Form For Disclosures of a Claimant's Protected Health Information, should be fully completed by the **patient**.
- The enclosed **Personal Representative HIPAA** form, Authorization Form For Disclosures of a Claimant's Protected Health Information to Personal Representative, should be completed if someone other than the patient needs to be able to discuss sensitive policy or claim information with our office. The patient may also provide a copy of a current **General Durable Power of Attorney** in lieu of this form.

This instruction form and our requests for additional information should not be considered a guarantee that payment will be made. Please make sure all documentation requested is fully completed and returned as soon as possible. If you have any questions, please contact our Customer Service Department.

Statement of Claim - Accident Expense - Individual Policy

To be completed by the Insured (Complete all applicable sections)				
Insured's name:	Insured's address: Phone: ()	<input type="checkbox"/> Check here if your address has changed	Policy/Certificate No.	
Insured's date of birth:	Social Security No.:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Employer's name & address:	
Claim is for: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse	Claimant's name (if not insured):	Sex of claimant: <input type="checkbox"/> Male <input type="checkbox"/> Female	Claimant's date of birth:	
If dependent child is over age 19, indicate: <input type="checkbox"/> Handicapped <input type="checkbox"/> Student	If full time student, give name and address of school:		Claimant's occupation:	
How did the accident happen?	Where did it occur?	Date of accident:	Time of accident: Hour A.M. P.M.	
		Employment related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Worker's Compensation claim filed? <input type="checkbox"/> Yes If yes: Date filed: _____ <input type="checkbox"/> No Claim #: _____	
Type of Treatment <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospital - OutPatient <input type="checkbox"/> Hospital - InPatient <input type="checkbox"/> M.D.'s Office	List full name and address of all facilities where treated for this condition:			
List full name and address of all Physicians who have treated you for this condition.				
INSTRUCTIONS FOR FILING AN ACCIDENT CLAIM				
<ol style="list-style-type: none"> 1. Please provide a copy of the Accident Report if one is available 2. Please provide an Itemized Emergency Room Bill with Diagnosis or Emergency Room Notes 3. Please provide copies of itemized bills and/or treatment notes which include the diagnosis for any other related treatment, such as hospital, physician, physical therapist or ambulance bil 4. The enclosed HIPAA form, Authorization Form For Disclosures of a Claimant's Protected Health Information, should be fully completed by the patient. 5. The enclosed Personal Representative HIPAA form, Authorization Form For Disclosures of a Claimant's Protected Health Information to Personal Representative, should be completed if someone other than the patient needs to be able to discuss sensitive policy or claim information with our office. The patient may also provide a copy of a current General Durable Power of Attorney in lieu of this form. 				
<p>Warning: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.</p> <p style="text-align: center;">I further certify that I have read and understand the above Fraud Warning Statement and the additional Fraud Warning Statements that appear on the back of this page that might apply to me or my family.</p>				
Date	Signature of CLAIMANT or Insured if Minor	Present Address		

FRAUD WARNING STATEMENTS

The law in **ALASKA** states: "A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony."

For your protection the law in **ARIZONA** states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal penalties."

The law in **ARKANSAS** states: "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."

For your protection the law in **CALIFORNIA** states: "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."

The law in **COLORADO** states: "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 payment from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory affairs."

The law in **DELAWARE** states: "A person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement containing any false, incomplete, or misleading information is guilty of a felony."

The law in **FLORIDA** states: "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."

The law in **IDAHO** states: "Any person who knowingly, and with intent to defraud or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading, information is guilty of a felony."

The law in **INDIANA** states: "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."

The law in **KENTUCKY** states: "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."

The law in **LOUISIANA** states: "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."

The law in **MAINE** states: "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 denial of insurance benefit."

The law in **MINNESOTA** states: "A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer, is guilty of a crime."

The law in **NEW JERSEY** states: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

The law in **NEW MEXICO** states: "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."

The law in **OHIO** states: "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 is guilty of insurance fraud."

The law in **OKLAHOMA** states: "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."

The law in **PENNSYLVANIA** states: "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."

The law in **TEXAS** states: "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."

The law in **VIRGINIA** states: "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."



AUTHORIZATION FORM FOR DISCLOSURES OF A CLAIMANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. I authorize all health care providers who have provided treatment or other health care services to me to disclose all information regarding my treatment to the Company's claims and underwriting representatives by and through the Company's contracted agent, LabOne.
2. The information which is described above will be disclosed to the Company to determine my entitlement to benefits under my health benefits plan or policy.
3. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Claims Department at P.O. Box 1604, Duncan, Oklahoma 73534-1604.
4. This authorization will expire twenty-four (24) months from the date the authorization is signed.
5. I understand that the information which will be provided under this authorization is necessary for the Company to evaluate my entitlement to benefits under my health benefits plan or policy and that the Company will condition the provision of payment of benefits to me on my providing this authorization, and my claim may be denied if I refuse to provide this authorization
6. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original.
8. I understand that I or my personal representative am entitled to receive a copy of this authorization upon request.

CONTINUED

If you are the representative of the claimant, describe the scope of your authority to act on the claimant's behalf:

Claimant Name

Name of claimant's personal representative, if applicable

Relationship of personal representative to the claimant

Signature of claimant (or claimant's representative)

Date of claimant's (or claimant's representative) signature

A signed copy of this form will be provided any time upon request.



**AUTHORIZATION FORM FOR DISCLOSURES OF AN INSURED'S PROTECTED HEALTH INFORMATION
TO DESIGNATED PERSONAL REPRESENTATIVE(S)**

I hereby authorize the use or disclosure of protected health information about me by Great American Life Insurance Company's Long Term Care Division or Loyal American Life Insurance Company or United Teacher Associates Insurance Company (hereinafter "the Company") as described below.

The purpose of this authorization is to allow the individual(s) listed below to act as my personal representative(s) in the disclosure, use or request of my protected health information. The Company may release my protected health information which is described below to the following person(s):

name	relationship	address	date of birth	social security #
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name	relationship	address	date of birth	social security #
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name	relationship	address	date of birth	social security #
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Describe fully the protected health information that is NOT allowed to be disclosed to the above named personal representative(s).

I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

As described in the Notice of Privacy Practices of the Company, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Officer at P.O. Box 26580, Austin, TX 78755-0580.

This authorization will expire upon the earliest of the following:

- a. the following date: _____; or
- b. twenty-four (24) months from the date the authorization is signed.

I understand that I am not required to sign this authorization form and that the Company will not condition the provision of payment to me on the signing of this authorization.

I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original.

I understand that I or my personal representative am entitled to receive a copy of this authorization upon request.

Insured Name

Name of personal representative, if applicable

Signature of Insured (or Insured's representative)

Relationship of personal representative to Insured

Date of Insured's (or Insured's Representative's) Signature

Insured Policy Number(s)