LIFESECURE INSURANCE COMPANY
P.O. Box 0042
New Hudson, MI 48165-0042

| Accident or Accidental Death Claim Form |

Instructions for Filing a Claim

- **Please fully complete all sections of this form to avoid delays in the processing of your claim:**
  - Sections A, B, C and D: All portions must be completed in full. The claimant must sign and date the statement at the bottom of page 2 and the Claimant Authorization on page 6.
  - Section E: Must be completed by the **physician** who initially treated the claimant for this accident. If the claimant was initially treated in a hospital emergency room, you may instead submit a copy of the emergency room physician's report which can be obtained from the treating hospital.
    If initially treated in a physician's office or urgent care center, you may submit the physician's office or urgent care center records and notes pertaining to the visit.
  - Section F: Must be completed and signed by the **policyholder/certificate holder** if he or she requests benefit payments to be directly deposited in his or her banking account.
- **Submit copies of all bills relating to this claim, such as hospital, emergency room, ambulance and physician office visit bills. All bills must include the diagnosis, and must show a complete itemization of all services rendered and the individual charge for each service. Bills that show only a summary of services and charges cannot be accepted.**
- **For each bill, we require a copy of the corresponding Explanation of Benefits (EOB) from your primary health insurance.**
- We require a copy of the police accident report and toxicology report (if applicable) for injuries due to motor vehicle accidents and any other incidents investigated by a law enforcement agency.
- Two authorization forms appear at the end of this document. The first authorization must be signed and submitted with your claim; the second authorization is optional and gives permission for someone you name to have access and receive information regarding your claim.
- Mail your claim to the above address, fax to 877.226.7315, or send electronically using your secure Personal Web Portal at www.YourLifeSecure.com (select "Policyholders" from the login menu). Your claim form, bills and EOBs must be submitted to us within 120 days from the date of loss or related service (or within the timeframe specified in your policy.) You do not need to wait until all bills and EOBs are received to begin sending your claim.

Section A: Policyholder/Certificateholder Information

First Name _____ MI _____ Last _____

Date of Birth (mm/dd/yyyy) _____ Policy No./Certificate No. _____

Street Address (P.O. Boxes cannot be accepted) _____ City _____ State _____ Zip _____

Home Telephone No. _____ Work Telephone No. _____

Section B: Claimant Statement

First Name _____ MI _____ Last _____

Date of Birth (mm/dd/yyyy) _____ Relationship (Self, Spouse, Child, Other) _____

Street Address (P.O. Boxes cannot be accepted) _____ City _____ State _____ Zip _____

Home Telephone No. _____ Work Telephone No. (if applicable) _____

Section B: Claimant Statement (continued from page 1)

Does the claimant have medical insurance? ☐ Yes ☐ No

Date of accident: _____/_____/_____ Time of accident: _____ ☐ a.m. ☐ p.m.

Location of accident (give exact address or nearest cross streets): _____

_____

Please provide a **detailed** description of how accident occurred.

_____

_____

_____

_____

_____

_____

Date of initial treatment by a hospital, emergency room, urgent care center or physician: _____/_____/_____

Body part(s) injured: _____

Did the accidental injury result in death? ☐ Yes ☐ No

Section C: Attending Physician Information

_____ _____

Name of Attending Physician Phone No.

_____ _____

Street Address City State Zip

Section D: Hospital, Emergency Room, or Urgent Care Center Information (if applicable)

_____

Name of Facility

_____ _____

Street Address City State Zip

_____ _____

Date Admitted (mm/dd/yyyy) Date Discharged (mm/dd/yyyy)

I certify that I have read and understand the fraud warning specific to my state as presented in this document.

_____ _____

➡ **CLAIMANT SIGNATURE** (To be signed by claimant or legal guardian if under age 18) Date

Section E: Attending Physician's Statement for Accidental Injury

To be completed only by the physician who initially treated the claimant for this accident. ***If the claimant was initially treated in a hospital emergency room, you may instead submit a copy of the emergency room physician's report which can be obtained from the treating hospital. If initially treated in a physician's office or urgent care center, you may submit the physician's office or urgent care center records and notes pertaining to the visit.***

Patient Information

Patient Name | Date of Birth (mm/dd/yyyy)

Physician Information

Physician Name (please print) | Tax ID No.

Phone No. | Fax No.

Street Address | City | State | Zip

Physician Statement

Diagnosis | Is diagnosis the result of an accident? ☐ Yes ☐ No

Date of Accident (mm/dd/yyyy) | Date of Initial Care for Accident (mm/dd/yyyy)

Please describe how and where the accident occurred:

Was patient hospitalized or treated in an emergency room or urgent care center for this accident?
☐ Yes ☐ No

Date of Admission (mm/dd/yyyy) | Date of Discharge (mm/dd/yyyy)

Facility Name | City | State | Zip

Was patient referred to you by another physician? ☐ Yes ☐ No

Physician Name (please print) | Phone No.

Street Address | City | State | Zip

➡ **PHYSICIAN SIGNATURE** ➡ **DATE**

Section F: Electronic Funds Transfer Information

Any benefits payable for this claim will be paid to the primary policyholder/certificate holder, regardless of claimant. If the policyholder/certificate holder wishes benefits payable for this claim be deposited directly to his or her checking or savings account, please provide the following information. If the policyholder/certificate holder prefers to be paid via a check by mail instead, please leave this section blank.

Name of Bank _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Account Type: ☐ Checking ☐ Savings

Account Number _____ Routing Number _____

➡ **POLICYHOLDER/CERTIFICATE HOLDER SIGNATURE** _____ ➡ **DATE** _____

MEDICAID ELIGIBILITY:
Your current or future eligibility for Medicaid may affect the payment of benefits provided by this Policy. State regulations may require payments be made to the Medicaid organization or to the medical provider and not you.

Fraud Warning:

For All States Not Listed Separately Below: 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.

To residents of **Alabama**: 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.

To residents of **Alaska**: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

To residents of **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.

To residents of **Arkansas, Louisiana, Rhode Island & West Virginia**: 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.

To residents of **California**: 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.

To residents of **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.

To residents of **DC: 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.**

To residents of **Delaware & Idaho**: 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.

To residents of **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.

To residents of **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.

To residents of **Kentucky**: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance 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.

To residents of **Maryland**: 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.

To residents of **Minnesota**: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

To residents of **New Mexico**: Any person who knowingly presents a false or fraudulent claim for payment of a loss of 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.

To residents of **Ohio**: 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.

To residents of **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.

To residents of **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.

To residents of **Tennessee, Virginia & 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 include imprisonment, fines and denial of insurance benefits.

To residents of **Texas**: 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.

LifeSecure Insurance Company
New Hudson, Michigan

Authorization to Disclose Medical and Confidential Information

This Authorization is intended to comply with HIPAA (the Health Insurance Portability and Accountability Act of 1996).

Individual About Whom Information May Be Disclosed

_____	_____	_____	
Name (full name)	*Date of Birth*	*Social Security Number*	
_____	_____	_____	_____
Street Address	*City*	*State*	*Zip Code*

Persons or Entities Authorized to Disclose Information

I authorize any physician, healthcare provider, hospital, medical facility, Veterans Administration, clinic, health plan, laboratory, pharmacy, pharmacy benefit manager, pharmacy-related organization, prescription drug database, care provider or evaluator, insurance company, employer, Social Security Administration, governmental agency, MIB, Inc., or consumer reporting agency to disclose medical or confidential information about me.

Description of Information To Be Disclosed

Any and all information related to my past, present or future health condition(s), medical care or treatment, or prescription drug history, which includes information about mental health (excluding psychotherapy notes), communicable diseases, HIV/AIDS, alcohol and substance abuse; as well as information contained in a consumer credit or investigative credit report including credit, motor vehicle and criminal records.

This Authorization CANNOT be used to disclose psychotherapy notes.

Purpose for the Disclosure

The purpose is to determine eligibility for coverage, administration, continuation, reinstatement, or replacement of coverage, and evaluation of contestability and eligibility for benefits under coverage.

Persons or Entities Authorized to Receive Information

LifeSecure Insurance Company, its agents, employees, representatives, reinsurers, and support organizations, and MIB, Inc.

Expiration and Revocation

This Authorization is valid for 24 months from the date shown below unless I specify an earlier date here: _____. This Authorization may be revoked at any time by giving written notice to LifeSecure at: LifeSecure Insurance Company, Privacy Office, 53200 Grand River Avenue, MC-L808, New Hudson, Michigan 48165. I understand revocation of this Authorization will not affect any contested claim for benefits or any action taken in reliance on this Authorization prior to receipt of written notice of revocation.

Important Information

- Refusing to sign this Authorization does not affect my ability to obtain medical treatment, but may prevent coverage from being issued or the Company from being able to determine whether benefits are payable under my coverage.
- LifeSecure is subject to federal privacy laws. However, if I authorize parties who are not subject to HIPAA to receive medical information about me, then such information may be re-disclosed and would no longer be protected under HIPAA. However, LifeSecure does require its agents and service providers to protect the confidentiality of medical information.
- I will receive a copy of this Authorization.
- A photocopy or facsimile of this Authorization is as valid as the original.

Signature

_____	_____
Signature	*Date*
_____	_____
Printed Name of Individual Signing this Authorization	*Relationship, if signed by legal representative – documentation of legal authority must be provided*

LS-18012 ST 04/23

lifesecure™

Standard Authorization Form to Disclose Protected Health Information (PHI)

Use this form to authorize LifeSecure Insurance Company to disclose your protected health information (PHI) to a specific person or entity. If you need assistance completing the form, please contact Customer Service at 1-888-575-8246. You must complete all the fields on this form.

WHEN COMPLETED AND SIGNED PLEASE MAIL TO:

LifeSecure Insurance Company
Privacy Office
53200 Grand River Avenue, MC-L808
New Hudson, MI 48165

Section A: The individual whose PHI is being disclosed:

First Name	Last Name	Suffix	Policy #
Social Security Number	**Date of Birth**		
Address	**City**	**State**	**ZIP**
Area Code & Telephone Number	**E-mail Address (if available)**		

Section B: Specific description of information to be disclosed:

Protected health information to be shared (check one)

☐ Any and all information (including personal, health, demographic, claims, billing and medical records)
☐ Only limited information (such as for specific treatments, dates of service or billing details) *(please describe)*

_____

Please check below if you would also like to include any of the following highly protected information (known as Super PHI):

☐ Substance abuse records (including alcoholism)
☐ AIDS or HIV treatment records
☐ Mental health services (does not include psychotherapy notes)
☐ Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases)

This authorization CANNOT be used to disclose psychotherapy notes.

Section C: Authorization and purpose:

I request and authorize LifeSecure Insurance Company to disclose my protected health information as described in this form. You may name up to three persons or organizations to receive your information using this form. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

(1)

Person / Organization authorized to receive your information	Relationship to Individual	Purpose
Address	**City**	**State**	**ZIP**

(2)

Person / Organization authorized to receive your information	Relationship to Individual	Purpose
Address	**City**	**State**	**ZIP**

(3)

Person / Organization authorized to receive your information	Relationship to Individual	Purpose
Address	**City**	**State**	**ZIP**

Section D: Expiration and revocation:

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed

☐ Other (insert date or event): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

Section E: Signature - This document must be signed by the individual, parent of minor child or the individual's Personal Representative:

This information is being released at my request. I understand that my treatment, payment, enrollment or eligibility for LifeSecure Insurance Company insurance coverage or benefits does not depend on whether I sign this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

Signature **Date: (month/day/year)**

Section F: If Section E is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the legal documents. You do **NOT** have to attach copies of these documents if they are already on file with LifeSecure Insurance Company.

_____ _____

Personal Representative's Name **Relationship to Individual**

_____ _____ _____ _____

Personal Representative's Address **City** **State** **ZIP**

_____ _____

Personal Representative's Area Code & Telephone Number **Personal Representative's E-mail address (if available)**

BEFORE RETURNING THIS FORM YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:
(1) MAKING A PHOTOCOPY OF THE SIGNED AUTHORIZATION; OR
(2) COMPLETING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

The Health Insurance Portability and Accountability Act of 1996 requires that we protect the privacy of your protected health information. You have a right to complain, in writing, about situations in which you believe we, or other organizations that work for us, have not met our responsibility to safeguard your protected health information. We cannot take away your benefits or retaliate against you in any way because of this complaint.

If you believe that LifeSecure Insurance Company has failed to protect the privacy of your protected health information you can file a complaint the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail, phone, or email at:

U.S. Department of Health & Human Services
200 Independence Ave, S.W., Washington, D.C. 20201

phone: 800-368-1019, TTD: 800-537-7697
email: OCRComplaint@hhs.gov.

Complaint forms are available at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf.

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the Privacy Office. Please forward requests for changes to the Privacy@yourlifesecure.com.