USAble Life

ACCIDENT BENEFITS CLAIM | PROCESS

FOR QUESTIONS, CONTACT CUSTOMER SERVICE AT 1-800-370-5856, MONDAY THROUGH FRIDAY, 8:00 AM TO 5:00 PM CST.

WHERE TO SUBMIT YOUR CLAIM:
Attention: Claims Department
Mail: P.O. Box 1650 | Little Rock | AR | 72203
Email: claims@usablelife.com | **Fax:** 501-235-8416

IMPORTANT NOTE

Please remember that claims must be received within 90 days (unless state law indicates otherwise) of the loss or date of service. Losses resulting from motor vehicle accidents or homicide require a copy of the investigating officer's report.

OBTAIN THE REQUIRED DOCUMENTS

To process your accident claim for **MEDICAL EXPENSES**, please submit the following documents:

You complete:
- ☐ **INSURED'S STATEMENT**
- ☐ **AUTHORIZATION TO RELEASE**
- ☐ **FRAUD NOTICE**

Please have your physician complete the **ATTENDING PHYSICIAN'S STATEMENT - MEDICAL EXPENSES, Emergency Room report,** or **office visit notes,** along with **itemized bills** from all medical providers.

To process your accident claim for **DISABILITY BENEFITS (ACCIDENT/SICKNESS DISABILITY RIDER – PRIMARY INSURED ONLY)**, please submit the following documents:

You complete:
- ☐ **INSURED'S STATEMENT**
- ☐ **AUTHORIZATION TO RELEASE**
- ☐ **FRAUD NOTICE**

Your physician completes:
- ☐ **ATTENDING PHYSICIAN'S STATEMENT - DISABILITY CLAIM**

Your employer completes:
- ☐ **EMPLOYER'S STATEMENT**

To process your accident claim for **ACCIDENTAL DEATH**, please submit the following documents:

You complete:
- ☐ **INSURED'S STATEMENT**
- ☐ **AUTHORIZATION TO RELEASE**
- ☐ **FRAUD NOTICE**
- ☐ **ACCIDENTAL DEATH CLAIM SECTION**

If the benefit amount is over $50,000, you will need to submit an original Death Certificate (copies are not accepted). If a police report is available, include a copy of the report with your claim. *Additional information may be requested.*

To process your accident claim for **WELLNESS BENEFIT**, please submit a **CLAIM FORM - WELLNESS BENEFIT**. The claim form can be downloaded from yourdocumentcenter.com.

SUBMIT YOUR CLAIM FORM & DOCUMENTS

To submit your claim via email, please scan your documents and **email to claims@usablelife.com**.

You can also send your claim via **fax to 501-235-8416**, or by **mail to ATTN: Claims Department, P.O. Box 1650, Little Rock, AR 72203**.

USAble Life

Accident Benefits
Statement of Claim

INSURED'S STATEMENT

Name of Insured	Social Security #	Age	Sex ☐ Male ☐ Female
Home Address (Number and Street) (City, State) (Zip)			Daytime Telephone ( )
Name of Person Suffering Loss	Date of Birth	Sex ☐ Male ☐ Female	Relation to Insured
Home Address (Number and Street) (City, State) (Zip)			
Loss Suffered			
Name of Claimant	Social Security #		Date of Birth
Relation to Insured			Claimant is ☐ Beneficiary ☐ Insured ☐ Other
Home Address (Number and Street) (City, State) (Zip)			Daytime Telephone ( )
Where Injury Happened (Street, City, State)	When Injury Happened (Date and Time)		Date of Death (if applicable)
How Injury Happened			

Names and addresses of all physicians who attended or prescribed for the insured in the past 5 years

Physician	Address	Dates of Attendance	Disease or Condition

Names and addresses of all hospitals where insured was treated within 5 years preceding accident.

Hospital	City/State	Dates of Treatment	Disease or Condition

I hereby authorize any physician or practitioner of the healing arts who has examined or treated me, and all hospitals, clinics or medically related facilities, insurance companies, health maintenance organizations, Medical Information Bureau, government entity (federal, state or local) or other organization, institution or person, that has any information, records or knowledge of me or my health, past or present, to furnish such information to USAble Life (or its representatives) and to permit them to examine and copy such information. I understand that USAble Life may disclose the information to the Medical Information Bureau, or reinsurers, or agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claims processing with the company.

A copy of this authorization, or the original, shall be valid for the duration of the claim from the date signed. I acknowledge that I have a right to a copy of this authorization upon request.

Date:_____ **Signature of Claimant:**_____

FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

CLAIMANT: PLEASE REMEMBER

1. To complete ALL questions and sign this form.
2. To obtain the Attending Physician's Statement(s).
3. To obtain a copy of the investigating officer's report if loss due to motor vehicle accident or homicide.
4. To obtain the Employer's Statement (Disability Riders and Principal Insured Only).
5. To attach ITEMIZED bills.
6. To complete the Authorization for Release of Medical Records.

ATTENDING PHYSICIAN'S STATEMENT - MEDICAL EXPENSES

Please Answer All Applicable Questions.

Name of Patient	Date of Birth

Nature of Injury (Include ICD Codes)	When Did it Occur?

Date Patient First Consulted You	Has Patient Ever Had Same or Similar Condition? ☐ No ☐ Yes If Yes- When: _____

If loss of limb, was it through or above wrist or ankle joint? ☐ Yes ☐ No

If loss of sight, is it permanent or irrecoverable? ☐ Yes ☐ No If Yes, on what date did it become so? Date:_____

If No, what percentage of sight remains?

Was the loss of sight or dismemberment solely due to accidental bodily injury without other causes? ☐ Yes ☐ No

If No, Please Explain:

Were any surgical procedures involved? ☐ Yes ☐ No Please Describe:	Date Performed

If loss due to burn, specify degree and size:

☐ First Degree
☐ Second Degree _____ Percentage of Body Surface Burned
☐ Third Degree _____ Square Inches of Body Surface Burned

If loss due to dislocation, complete separation? ☐ Yes ☐ No Open Reduction ☐ Closed Reduction ☐

If loss due to fracture:

☐ Simple ☐ Open Reduction
☐ Compound ☐ Closed Reduction

If loss due to laceration:

Total Length
☐ Less than 5.08 cm.
☐ 5.08 - 15.24 cm.
☐ Greater than 15.24 cm.

Type of repair
☐ Stitches ☐ Glue
☐ Staples ☐ Other

I certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Physician's Signature	**Date**

Physician's Name	**Degree**

Address	**Telephone ( )**	**Fax ( )**

City	**State**	**Zip**

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CLAIMANT: PLEASE REMEMBER

1. To complete ALL questions and sign Insured's Statement.
2. To attach ITEMIZED bills from all medical providers.
3. To Complete the Authorization for release of Medical Records.

RETURN TO:
USAble Life
P.O. Box 1650
Little Rock, AR 72203

ATTENDING PHYSICIAN'S STATEMENT - DISABILITY RIDER

Name of Patient | Date of Birth

HISTORY

(a) When did symptoms first appear or accident happen?

(b) Date patient ceased work because of disability

(c) Has patient ever had same or similar condition? ☐ Yes If "Yes" state when and describe ☐ No

(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

(e) Name and address of other treating physicians

DIAGNOSIS

(a) Diagnosis (including complications) and ICD-9 Code

(b) If pregnancy, (E.D.C.)

(c) Objective findings (including current x-rays, EKG's laboratory data and any clinical findings)

TREATMENT

(a) Date of first visit

(b) Date of last visit

(c) Frequency of visits ☐ Weekly ☐ Monthly ☐ Other (Specify)

(d) Nature of treatment (including surgery and medications prescribed, if any)

PROGRESS

(a) Is patient ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?

(b) Is patient ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?

(c) Has patient been hospital confined? ☐ Yes ☐ No
If yes, give Name and Address of Hospital _____ Confined from _____ through _____

PROGNOSIS

(a) Is patient now totally disabled?
Patient's Job ☐ Yes ☐ No
Any Other Work ☐ Yes ☐ No

(b) When do you expect a fundamental or marked change in the future? ☐ 1 Mo. ☐ 1-3 Mos. ☐ 3-6 Mos. ☐ Never Applies To: ☐ Patient's job ☐ Other Work

REHAB

(a) Is patient a suitable candidate for occupational rehabilitation? Patient Job ☐ Yes ☐ No ANY OTHER WORK ☐ Yes ☐ No

(b) When could trial employment commence? Patient's Job Date:_____ ☐ Full-time ☐ Part-time Any other work Date:_____ ☐ Full-time ☐ Part-time

REMARKS

(Limitations, Therapy, etc.)

Physician's Name (Print) | Degree | Telephone ( ) | Fax ( )

Street Address | City or Town | State or Province | Zip Code

Signature | Date

EMPLOYER'S REPORT OF CLAIM

TO BE COMPLETED BY EMPLOYER

CLAIMANT

1. Employee Name:

2. Social Security No.

3. Date of Birth

4. Occupation at time last worked

5. Work schedule at time last worked No. of days per week _____ No. of hours per day _____

6. Employee's Date of Hire

7. Date employee was actually last present at work

8. Has employee returned to work? ☐ Yes ☐ No ☐ Part-time Date:_____ ☐ Full-time Date:_____

EMPLOYER

9. Employer Name

10. Date

11. Signature

12. Title

13. Name (Please Print or Type)

14. Telephone ( )

15. Address

16. City, State, Zip

17. Fax ( )

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ATTENDING PHYSICIAN'S STATEMENT - ACCIDENTAL DEATH

Please complete if claim is for loss of life.

Name of Deceased	Age at Death

Residence at Time of Death (Number and Street)	(City, State)	(Zip)

Date of Death	Place (if in hospital or institution, give name)

Cause of Death (Including ICD Codes)

Was Death Due To: ☐ Accidental Bodily Injury ☐ Homicide ☐ Other (Give details in Remarks section)

Give Details and Date

Were there any contributing causes of death? Give the dates and duration of each as closely as you can.

Was there an autopsy, inquest, or post mortem examination? By whom?

Remarks:

_____

_____

_____

I certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Physician's Signature	**Date**

Physician's Name	**Degree**

Address	**Telephone ( )**	**Fax ( )**

City	**State**	**Zip**

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CLAIMANT: PLEASE REMEMBER

1. To complete ALL questions and sign Insured's Statement.
2. To obtain the investigating officer's report if loss due to motor vehicle accident or homicide.
3. To attach a CERTIFIED copy of the death certificate.

⚠ USABLE® LIFE | **FRAUD NOTICE**

FOR YOUR PROTECTION, THE LAWS OF SOME STATES MAY REQUIRE US TO FURNISH YOU WITH THE FOLLOWING NOTICE:
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. Please see below for special notices required by state law.

AL Residents Only: 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.

AK Residents Only: Any 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.

AZ Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA Residents Only: 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.

CO Residents Only: 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.

DE, ID, IN, OK Residents Only: 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.

DC Residents Only: 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.

FL Residents Only: 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 of the third degree.

KS Residents Only: 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 may be guilty of a crime and subject to fines and confinement in prison as determined by a court of law.

KY Residents Only: 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.

ME and TN Residents Only: 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 and denial of insurance benefits.

MD, RI, TX Residents Only: 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.

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

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

OH Residents Only: 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 is guilty of insurance fraud.

OR Residents Only: 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 may be guilty of a crime and subject to fines and confinement in prison.

PA Residents Only: 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.

VT Resident Only: 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.

VA and WA Residents Only: 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.

▼ SIGN AND DATE BELOW

I have read and understand the Fraud Warning that applies to my state of residence.

LAST NAME, FIRST NAME, MI *(PRINTED)*	SIGNATURE	TODAY'S DATE